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(Deceased January 2, 1947)
AND
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Texas State Journal of Medicine

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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION AND PUBLIC HEALTH IN TEXAS

Our Position in the Wagner-Murray-Dingell Bills Legislation in the Congress is set forth in a fairly, though not completely comprehensive statement filed with the Committee on Education and Labor of the United States Senate, as a part of the hearing being conducted by that Committee on the Wagner-Murray-Dingell Bill (S. B. 1606). The statement was filed over the signature of the President and Secretary of the State Medical Association of Texas, which makes it official, as nearly as anything of the sort can be official. The Committee on Public Relations participated in the preparation of the statement.

The statement in full, was given publicity through newspaper releases, and other channels available to our Committee on Public Relations, and we have received many very fine compliments with reference to both the position taken and the manner of presentation. Particularly has this statement been compared with evidence adduced by the Committee on Education and Labor during this hearing, by advocates of the legislation in question, many of whom have indulged in utterly uncalled for misrepresentation, abuse, and ridicule. We feel that we should compliment our Committee on Public Relations and all who participated in the preparation of the statement, in connection with the dignified and very informative expression of views of our Association on this very important problem. It is our hope that we continue along such lines.

The advocates of this and similar legislation, for the most part, are of the crusader type, and, therefore, quite intolerant of opposition. They are somewhat in the position of the blind man who felt of the elephant's trunk, and gave it as his opinion that the elephant was an animal shaped very much like a large snake. Or, perhaps we should make the comparison with the observation of another blind man, who felt the elephant's tail, and concluded that the elephant was more or less like a rope. At any rate, the advocates of the legislation setting up socialized medicine in this country are apparently convinced the legislation is practically an accomplished fact, and are visibly and audibly peeved at any opposition.. We are advised that at a conference recently held in Washington, D. C., the conferees were told that the accomplishment of the program was assured, and all that needed to be decided was how it would fit into the health service in each of the states. While we are not inclined to discuss the matter of socialized medicine in this editorial, we are insisting that the accomplishment of the fact of socialized medicine is certainly not in the near or even foreseeable future. Certainly it is not if a majority of the doctors in this country don't want it and won't have it. It is our opinion that the doctors don't want it and won't have it, and that the people, certainly those who are patients of competent, conscientious doctors, would not like it.

So important do we consider the statement referred to above, that we are reprinting it here, in full. It is addressed to the Honorable

James E. Murray, Chairman of the Committee on Education and Labor of the United States Senate, and is signed by President Dr. H. F. Connally and Secretary Dr. Holman Taylor. The statement follows:

"The State Medical Association of Texas, with a membership of 6,000 practicing physicians, appreciates your courtesy in permitting us to go on record as being opposed to the enactment of Senate Bill 1606—the Wagner-Murray-Dingell bills.

"Our investigations show us that not only the physicians of Texas but the citizens of Texas by an overwhelming majority are definitely opposed to the Wagner-Murray-Dingell bill, inasmuch as it constitutes compulsory prepaid health insurance under Federal control.

"As evidence of this definite state-wide opposition on the part of the people of Texas, we point to the fact that a large section of the Texas press, including both large daily newspapers and small country weeklies, have placed themselves editorially on record in opposition to this proposed legislation. We also would respectfully call your attention to the fact that the representatives of the State of Texas in the Congress have, by a large majority, gone publicly on record as being opposed to this Federal legislation. Texas is a pioneer state, a vigorous, fast growing commonwealth. The average Texan thinks and speaks for himself, and above all things jealously guards his freedom of choice in matters which affect his personal liberty and pursuit of happiness. Texans gained their liberty by fighting for it and it is not thinkable that a citizenry which holds such a pride in their State as do Texans, will willingly agree to the regimentation of themselves and their affairs, during peace time, by any Federal agency. We venture to say, judging from the expressed attitudes of the press of Texas and its duly elected representatives in Congress, that should the matter of compulsory Federal health insurance be put to a vote of the people of Texas it would be defeated at the polls by an overwhelming vote. The people of Texas do not want Federal medicine. They wish to retain their full liberty to select and patronize the physicians of their choice without being handicapped in even the smallest way by any Federal law or directive.

"As to Senate Bill 1606 and its many complicated details, we wish you to know that a majority of the State Medical Association of Texas, all its officials and all its committees, have read this bill and studied it in detail. In fact, special group meetings of doctors have been called for the purpose of reading the bill in full and discussing its multitudinous and complicated provisions. In their considerations of the Wagner-Murray-Dingell bill the members of the State Medical Association of Texas have attempted to consider the measure impartially and quite unselfishly. Their attempt has been to reach a very simple conclusion — would the Wagner - Murray-Dingell bill be helpful to the health, welfare and happiness of the seven million people who live in the State of Texas? Our considered conclusion is that this bill would not better public health in Texas. On the contrary, it would tend to destroy the present system of Americanized medicine in our State by substituting Federal control, and the health, welfare and happiness of Texans generally would soon be seriously and adversely affected.

"In regard to Title I of S-1606, the State Medical Association of Texas certainly stands in full approval of Federal grants in aid to the States for establishing and maintaining adequate measures for the prevention, treatment and control of venereal disease and tuberculosis, the extension of the public health service, and the extending of maternal and child health care to all mothers and children, where personal payment for such service would constitute a hardship. Similarly, the State Medical Association most certainly favors Federal grants in aid for the purpose of providing full medical care and hospitalization for the indigent. One section of the bill which would seem objectionable is the provision for training thousands of employees in public health work in some central Federal educational set-up in Washington. We believe that such training should be decentralized, and that training of public health employees could more efficiently be carried out in the hospitals, universities and other centers of medical education distributed throughout the United States. In such a manner the trainees could more readily become acquainted first-hand with widely varying health problems than they could if they were forced to secure such training in the highly political atmosphere of Washington, D. C.

"As to the provisions for Federal aid in the prevention and control of venereal diseases and tuberculosis, it is our opinion that laws already on the Federal statute books make ample and sufficient provisions for these activities.

"As to the construction of hospitals in locations where they are needed, we believe that this important matter is fully covered by the Hill-Burton (S. 191) bill which has already passed the U. S. Senate and is now under consideration by the House of Representatives. This bill, which depends upon various States to make surveys as to where hospitals are most needed and where they would be self-supporting by the contiguous population, appears to us to be the full and complete answer to the hospital construction problem. The Hill-Burton bill has been endorsed as to principle by the Legislative Committee of the State Medical Association, and has the full endorsement of the American Medical Association.

"In regard to scientific and medical research, it seems to us that this is adequately taken care of in the amended Magnuson bill, S-1850, which measure meets with the hearty approval of the American Medical Association and which undoubtedly will be endorsed by the State Medical Association at the earliest opportunity.

"The State Medical Association of Texas is opposed in every particular to Title II of the Wagner-Murray-Dingell bill, which provides for prepaid personal health service benefits, and we believe that the people of Texas are similarly opposed. No matter what any person, however exalted his position, might say in this regard, we are fully convinced that compulsory prepaid health insurance is definitely socialistic. When the Government goes into business, establishes a system of insurance to which everyone must contribute; when it regulates the provision of medical service through Washington; when it regulates fees that doctors are to receive when they participate in the system; when it regulates consultations and determines when consultants are to be consulted, we respectfully submit that this is very definite socialized medicine. We believe that such a system, which interposes great groups of non-medical Federal employees between the public and their doctors would constitute a medical system both undemocratic and un-American.

"We believe that no universal plan of compulsory prepayment health insurance could ever be successful, or be operated efficiently unless the medical profession is thoroughly in accord with such plan and wholeheartedly coöperates in its administration. On the face of it, so far as Texas is concerned, hardly a doctor gives compulsory health insurance his approval.

"The State Medical Association of Texas and the many county medical societies representing the 254 counties of this State, are all on record as opposing

this compulsory medical insurance plan. Their reasons are many and cogent. They feel that so far as Texas is concerned, with its wide-open spaces and vast areas which are thinly populated, such a complicated insurance system could be operated only under extreme difficulties. It is repugnant to the doctors of Texas that this proposed law, if forced upon them, would compel them to devote many hours of their valuable time, which might be used in caring for the sick, to the making of voluminous reports, in triplicate, to Federal bureaus in Austin and/or Washington.

"The State Medical Association further feels that the Wagner-Murray-Dingell bill, which puts into the hands of one man, the Surgeon General of the United States Public Health Service, a tremendous power which could be wielded through one vast central agency in Washington, presents political implications both clear and dangerous. While it is true that an advisory council of 16 members is provided for, yet it should be noted that such council would be appointed by the Surgeon General himself, with the approval of the Federal Security Administration. Such a council, widely scattered throughout the United States, would likely consist of members fully in accord with the political policy of the Surgeon General, and like so many other councils of an advisory nature would, in effect, be innocuous and more or less a figurehead. The State Medical Association believes that there would be definite danger of absolute dictatorship under any law which would give the Surgeon General practically the sole authority to employ doctors and specialists, establish fee schedules for physicians, fix the qualifications of specialists, determine how many patients any doctor might have, designate and regulate hospitals and clinics to provide service and negotiate contracts with public agencies, non-profit groups and individuals for providing full medical benefits.

"It is our firm belief that such stringent Federal regulations affecting medicine would definitely destroy the private practice of medicine in the United States. Americanized medicine, under Federal control, would forever lose the time honored relationship between physician and patient and patient and physician, which is the base of its entire structure. The initiative of every doctor restricted and regulated by Federal law would be seriously handicapped and medical research and scientific progress on the part of individual doctors would soon become a thing of the past. The quality of medical care would deteriorate and the independence and self-respect of every practicing physician would correspondingly suffer.

"The original Wagner-Murray-Dingell bill, S-1050, which was referred to the finance committee of the Senate, did give some indication of the tremendous financial burden which it would impose upon the American public. The new Wagner-Murray-Dingell bill, S-1606, is being considered without a single definite figure to indicate its cost or its terrific tax burden. The people of Texas, as well as the physicians of this State, realize quite well that the matter of dodging the financial requisites was not without a political bearing. However, since in this world nobody ever gets something for nothing, the American public eventually will have to foot this bill, and we believe that every worker and every employer will be surprised and shocked at what they will have to pay for compulsory health insurance if instituted by the Congress. Such payments, if estimated on the financial figures of the first Wagner-Murray-Dingell bill, would mean the collection by the Federal government of between three and four billion dollars annually from the people of America for this single purpose. It would seem only fair to the people of the United States that a more definite figure of the cost of the Wagner-Murray-Dingell bill should be made public. Under the present circumstances the people are being asked to accept an additional tremendous financial burden, whether it is called contributions or taxes, the import of which the average citizen is at present unsuspecting and unaware. With Federal, State and local taxation practically at an all time high this additional demand would make the present grievous tax burden almost impossible to bear. We believe that if the American public was thoroughly cognizant of what this proposed legislation would cost them, both workers and employers would demand the Wagner-Murray-Dingell bill die in your committee.

"The State Medical Association of Texas strongly advocates wide-spread prepaid health insurance to cover every family and every individual in the State, but it wishes such insurance to be voluntary and not compulsory upon the individual. Furthermore, the doctors of Texas favor the expansion of such insurance as offered by private enterprise rather than through Federal direction and control. Voluntary prepaid health insurance can be provided, and is provided, at a far less cost than contemplated in this proposed Federal legislation. The State Medical Association of Texas is actively upholding and sponsoring worthy programs for prepaid hospitalization and medical and surgical care. The State Association has gone on record as approving both non-profit and commercial prepaid health insurance plans, provided only that such plans are financially sound, give free choice of doctors and do not destroy the relationship between physician and patient. In particular, the State Medical Association of Texas has approved the Blue Cross Group Medical and Surgical Service in Texas, a non-profit organization. Similarly, it will approve other non-profit plans, and by approval it means that the doctors of Texas are actively supporting such plans.

"Estimating from the provisions of the former Wagner-Murray-Dingell bill, S-1050, that every worker would have to pay 3 per cent of his earnings for compulsory health insurance, we wish to compare such payments with the cost of voluntary hospitalization and essential medical and surgical care as provided by the Blue Cross plan in Texas. Taking the average worker, earning the annual wage of $2,600.00, 3 per cent of such wage paid for compulsory health insurance would amount to $78.00 annually. This would cover the worker alone. The Blue Cross plan, when both hospitalization and essential medical and surgical care are included, would cost this worker and his whole family, no matter how many children, $4.10 a month or $49.20 a year. This would be a saving of $28.80 in actual cash expended by the individual worker. Full hospital and essential medical and surgical care is offered to the unmarried person for $1.65 a month by the Blue Cross in Texas, with a corresponding saving, when compared with the exhorbitant rate likely for compulsory Federal coverage. Under the provisions for the first Wagner-Murray-Dingell bill, S-1050, which is our only possible yardstick for estimating Federal health insurance cost, an unmarried worker earning $3,600.00 a year—the top bracket under the proposed law—would have to pay $108.00 annually to the Government for this compulsory protection. A combination hospital, medical and surgical policy with the Blue Cross in Texas could be bought by this unmarried worker for $19.80 a year, a saving of $88.20 a year. The essential health insurance coverage under the Blue Cross Plan would have the approval of the State Medical Association of Texas, and is as broad and as efficient as any plan which could be offered by the Federal Government.

"The State Medical Association of Texas will continue to use every effort in support of voluntary prepaid health insurance provided through private en-

terprise, believing that the voluntary system is the best system, the least expensive system and the most truly American system.

"There is no need for Federal medicine or its socialistic set-up, with low cost voluntary health insurance so widely available to the American public.

"In conclusion, we urge that your committee report unfavorably upon the Wagner-Murray-Dingell bill, S-1606, in all particulars."

The American Medical Association Will Meet in San Francisco, Calif., July 1-5, 1946. The medical profession of Texas, particularly those physicians who are members of the State Medical Association and therefore of the American Medical Association, are thus officially notified of that fact. This will be the Ninety-fifth Annual Session of the Association. The House of Delegates will convene July 1, and will remain in session until it has finished its business.

The State Medical Association of Texas is entitled to five Delegates, at least for this meeting of the House of Delegates. There will be a new apportionment this year, based on membership of the several constituent state associations. Texas may gain a Delegate in the apportionment thus to be made. It lacked a very slight number of members of having enough for six Delegates in the last apportionment.

The Scientific Assembly of the Association will open on the evening of July 2, and the Scientific Sections will take over the next morning, and continue through the balance of the session.

The House of Delegates will convene at the Hotel St. Francis, Union Square. The Scientific Sections will be variously located. Information pertaining to the convention will be published from time to time in *The Journal of the American Medical Association.*

A Real Cancer Research Program Under Way.—Apparently cancer research during the past has been very largely an individual or, at most, but loosely connected matter. That so much progress has been made in the field of cancer speaks well for those who have done the work, whether individually or collectively. During the recent past, those who have been giving the matter study with the idea of doing something about it have come to the conclusion that several things must be done, the sooner the quicker, and the more thoroughly the better.

There are many activities in the field which could well and doubtless will coöperate closely. It will be remembered, in this connection, that there is a difference between coöperation and taking orders. It would appear that the program can be brought into common and coöperative lines without conflicts of interest between groups. Even the element of treatment, which seems to bring about much controversy in the campaign, can be so handled that the good to be derived therefrom, whether or not in the course of research, can be equably distributed throughout the state.

Those interested in the cancer problem in Texas appear to be accepting the American Cancer Society views as to what should be done about it all, thus setting the stage for productive coöperation. A dictum of the American Cancer Society is "Research, Education and Service." There certainly must be a thorough spread of information about cancer, both to the medical profession and the laity, each in accordance with his requirements, and there certainly must be diagnostic and treatment centers set up throughout the state, in order that research material may be made available. The Cancer Committee of the State Medical Association has recommended that this be done in accordance with the Councilor Districts of the State Medical Association.

All of this, and much more which cannot be discussed here, requires money, and in large amounts. Nationally, not so much effort has heretofore been made to raise money. In 1945, there was a determined effort to this end, and approximately $4,000,000 was raised throughout the nation, of which amount $1,000,000 has been made available for research on a national scale. It is expected that $12,000,000 will be raised this year. Of the amount raised through the national campaign, 60 per cent will be retained by the states in which the money is raised. The American Cancer Society has entered into an arrangement with the National Research Council of the National Academy of Sciences under which this collection of high-power men of science will direct the research activities through a special committee established for the purpose and known as the "Committee on Growth." This committee will coördinate and supervise all the research activities of the Society through the channels of chemistry, physics, biology, and clinical research. Considerable money is being made available for fellowships.

We mention these matters not so much as information as assurance that something definite, consistent, and continuous is going to be done about the very serious and disastrous disease of cancer. The work in Texas will be conducted by a newly created Division of the American Cancer Society with a Board of Directors on which are represented most of the agencies in the state having a logical or a legal interest in this problem. The majority of the Board must be physicians and there are included the members of

the Executive Council of the State Medical Association as well as the five members of the Association's Cancer Committee. The Division has employed a whole-time Executive Director, who will work on a statewide basis under the direction of an executive committee which includes the members of our cancer committee. He will work in the closest possible coöperation with the state cancer hospital, with the State Departments of Health, Welfare, and Education, and with the colleges of medicine and dentistry as well as with the State Medical Association through its cancer committee and executive Council. There are details to be worked out, but the encouraging thought is that something definite is being done about it.

Attention is directed to the Symposium on Cancer Research published in this number of the JOURNAL (page 41). This is the beginning of a study program, and a very good beginning, at that. There will be more of the same, and quite frequently.

The Retirement of Dr. Olin West, as Secretary-General Manager of the American Medical Association, takes from the greatest medical organization on earth the greatest Secretary-Manager we have ever known. We are grateful to Dr. West for his services, and hopeful that his retirement will be to his liking, and certainly that the state of his health will be conducive to that well-being which alone can make the decling years of an active man what they should be.

It would be futile to undertake adequately to evaluate the services of Dr. West except in a biographical sketch proper, We will content ourselves with quoting from an editorial in the March 30, 1946, number of *The Journal of the American Medical Association:*

"Dr. Olin West came to the American Medical Association with a record of experience in medicine and public health that especially fitted him for the positions that he assumed. His preliminary education was received at Howard College in Alabama, in which state he was born at Gadsden on July 12, 1874. He graduated from Vanderbilt University School of Medicine, Nashville, Tennessee, in 1898. In 1910, after twelve years of practice in Nashville and fifteen years as a member of the faculty of Vanderbilt University, first as instructor and later as assistant professor and associate professor in chemistry, Dr. West became director of the Rockefeller Sanitary Commission and International Health Board in Tennessee. Here he was especially effective in the great campaign against hookworm infection. In 1918 he became secretary and executive officer of the Tennessee State Board of Health and after four years gave up that position to become field secretary of the American Medical Association in association with Dr. Alexander Craig, who was at that time Secretary. Following the death of Dr. Craig, Dr. West was appointed Secretary by the Board of Trustees. Then when Dr. George H. Simmons resigned as Editor and General Manager of the Association in 1924, Dr. West continued in the position of Secretary and succeeded to the duties of General Manager.

"In the early activities for the organized medical profession Dr. West was president of the Middle Tennessee Medical Association and later secretary of the Tennessee State Medical Association and editor of its journal. His love for the art and tradition of medical science, his great personal compassion, his geniality and his friendliness have endeared him personally to many thousands of American physicians who have met him in office and who have had advantage of his personal counsel and judgment."

Addition to the Library Building Fund of the State Medical Association in the sum of $80.00, has been made since the list was published in the April JOURNAL. While all of these contributions will be acknowledged through the Report of the State Association Committee on Library Endowment, at the annual session, at Galveston, May 6-9, we will keep the editorial list up to date by the publication of the following additional contributions:

Austin-Waller Counties Medical Society	$ 5.00
Dallas County Medical Society	
Dr. Oscar M. Marchman, Dallas	25.00
Hardin-Tyler Counties Medical Society	
Dr. W. J. Poshataske, Silsbee	15.00
LaSalle-Frio-Dimmit Counties Medical Society	
Dr. B. E. Pickett, Sr., Carrizo Springs	25.00
Tarrant County Medical Society	
Dr. R. B. Anderson, Fort Worth	10.00
Wharton-Jackson - Matagorda - Fort Bend Counties Medical Society	
Drs. Frank R. Rugeley and F. J. L. Blasingame, Wharton	25.00
	$105.00

CURRENT EDITORIAL COMMENT*

The Treatment of Rheumatic Fever.—With the widespread recognition of the fact that rheumatic fever is responsible for more deaths in the school age period than any other disease, as well as being an important cause of cardiac crippling in later life, renewed interest is being centered upon the causes, treatment, and prevention of this disease. The following constitutes a brief resume of some of the newer aspects of treatment.

Treatment of the Active Phase.—Absolute bed rest is regarded by all as essential in the active phase of the disease, which is defined as that period during which the patient exhibits symptoms and signs of infection and/or laboratory evidence of rheumatic activity. The temperature curve, pulse rate, erythrocyte sedimentation rate, and white blood cell and differential count constitute useful guides in evaluating the patient's

*This department of the JOURNAL presents editorial comments on current items pertaining to the science, art and practice of medicine, contributed by members of the State Medical Association and scientists closely associated with the medical profession of Texas. Invitation is hereby extended to any member of the State Medical Association of Texas to submit such discussions for this department. The discussions should not be more than 500 words in length.

progress. The diet should be liberally supplied with the so-called protective foods and a high vitamin supplement should be added. Salicylates have been used for years to control the exudative manifestations of rheumatic infection and Coburn has recently claimed that massive doses of sodium salicylate will actually shorten the course of the rheumatic infection by preventing the progression of the pathological process. He recommends maintaining the blood salicyl level at or above 35 mg. per 100 cc., which necessitates the administration of 0.2 to 0.3 Gm. of the drug per kilogram per twenty-four hours.

Coburn's observations have not been adequately confirmed and some dissenting opinions have already appeared in the literature, but this form of therapy deserves more widespread trial, provided one is alert to the dangers of acute salicylism. Any patient treated in this manner should be observed carefully for signs of toxicity, which include tinnitus, nausea and vomiting, hyperpnea and tachypnea, skin rashes, thrombocytopenia, and eventually severe intractable acidosis, coma, and death. Children are particularly susceptible to salicylate poisoning, and the drug should be given to them with caution. We believe that any toxic manifestation more severe than tinnitus and nausea constitutes an indication for stopping therapy. Since salicylates quite commonly induce hypoprothrombinemia and thus predispose to hemorrhage, vitamin K, in doses of 2 to 5 mg. per day, should be made an integral part of salicylate therapy, and the patient's prothrombin time should be checked at periodic intervals.

Not only are the sulfonamide drugs ineffective in the treatment of acute rheumatic fever, but there is some evidence that they are actually harmful. Swift has reported that the sulfonamide drugs aggravate rheumatic activity and also tend to be more toxic for the rheumatic than for the nonrheumatic person. Several recent reports on the use of penicillin in the treatment of acute rheumatic fever have indicated that this antibiotic is of no value.

Congestive heart failure may occur during an acute rheumatic episode, and in younger persons is almost always due to active rheumatic carditis rather than mechanical failure. The treatment of this complication is essentially the treatment for congestive heart failure from any cause. There is still some controversy concerning the use of digitalis during acute rheumatic carditis, but most workers are agreed that congestive failure constitutes an indication for digitalis therapy, although it is admittedly less effective when an acutely diseased myocardium is the precipitating cause. The patient should be observed carefully for toxic symptoms during digitalization, bearing in mind that digitalis may precipitate heart block in a person whose conduction time is already slowed by rheumatic carditis. If diuretics are to be administered, they should be given prior to digitalis therapy, since a sudden diuresis may increase the effective concentration of digitalis in the system to the point where toxic manifestations may occur.

Intervals Between Attacks.—There is an unfortunate tendency among physicians to keep rheumatic fever patients in bed for long periods of time, sometimes months or years, regardless of the status of their infection. Although almost everyone agrees that the treatment of the acute attack necessitates absolute bed rest, there is a growing conviction that bed rest in the absence of active infection is not only of no avail, but may actually be harmful. All the evidence indicates that the progression of the rheumatic lesion occurs during the period of active carditis, and that after healing has occurred, exercise does not further the progression of the lesion. After signs of active infection have subsided, the patient should be permitted out of bed and gradually allowed to resume activity to the point of tolerance.

In many persons, the functional capacity of the heart appears to be unimpaired in spite of the persistence of murmurs, and it is our conviction that such persons should be allowed to engage in all forms of exercise which do not induce dyspnea or exhaustion. This regime has been without ill effects in many of the large rheumatic clinics over the country and does much to prevent development of a cardiac neurosis. The question of elimination of foci of infection in a quiescent interval is one which is still *sub judice*. Analysis of several large series of patients has failed to reveal that tonsillectomy decreases the number of rheumatic recrudescences. Most workers believe that the same indications for the removal of infected foci should be used in rheumatic subjects as are used in nonrheumatic persons. It is important to guard against the development of upper respiratory infections in rheumatic persons by attaining optimum nutrition and striving for good hygiene in every day life.

Prophylactic Use of Sulfonamides.—Although the sulfonamide drugs are ineffective in the treatment of the acute attack, recent experience has indicated that they are remarkably effective in cutting down the incidence of rheumatic recrudesences. Most workers have used sulfanilamide for this

purpose, but the indications are that sulfadiazine is at least as effective. The drug is administered in daily doses of from 1 to 2 Gm. the object being to maintain a level of from 2 to 3 mg. per 100 cc. of blood. At this dosage level, very few drug reactions have been encountered. It is a wise precaution to check the hemoglobin and leukocyte count weekly for a period of four to six weeks after starting drug therapy, since the few drug reactions which have been reported have occurred early in therapy. The present evidence would indicate that this type of prophylactic medication should be continuous throughout the year for a period of several years.

GLADYS J. FASHENA, M. D.
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TRANSTHORACIC RESECTION OF THE CARDIA AND ESOPHAGUS

O. THERON CLAGETT, M. D.*
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The development of the transthoracic approach to lesions that involve the lower portion of the espohagus and the cardia of the stomach is a recent surgical achievement although the desirability of such a procedure long has been recognized. Real progress in this field required the development of methods of anesthesia for such operations, an understanding of the physiologic changes that occur in the cardiac and respiratory systems when the thorax is opened, and the development of means of controlling these changes.

With present knowledge, the thorax is just as accessible to surgical exploration as is the abdomen and the risk of thoracotomy is no greater than that of laparotomy. It is no longer necessary to deny any patient the benefit of surgical resection for lesions of the lower part of the esophagus or upper part of the stomach merely because of their anatomic location. The scope of the field that has been opened by the development of the transthoracic approach is indicated by the fact that 10 per cent of all carcinomas of the stomach occur in the cardia and 33 to 50 per cent of all carcinomas of the esophagus occur in the lower third of the esophagus. Since the stomach is the most common site of carcinoma and the esophagus ranks as the fourth most common site, it becomes apparent that the cardia of the stomach and lower part of the esophagus present one of the major problems in surgical treatment of malignant disease and, therefore, that the transthoracic approach is of great importance.

As long ago as 1895, Biondi[3] attempted esophagogastrostomy on dogs. In 1907, Wendel[10] attempted the procedure on a patient but was unsuccessful. Voelcker[9] in 1908 performed the first successful esophagogastrostomy on a patient after removing a carcinoma of the cardia by a transabdominal route. Adams and Phemister[1] reported the first successful operation by the transthoracic route in 1938. Since that time successful operations for a variety of lesions in the cardia and lower part of the esophagus have been reported by a number of surgeons, notably Churchill and Sweet,[5] Garlock,[6, 7] Adams and Phemister,[1] Carter, Stevenson and Abbott,[4] and Ochsner and DeBakey.[8] Gradually the technic for transthoracic resection of the lower portion of the esophagus and the cardia has been developed and improved.

At present, the risk of transthoracic operations on the stomach is not much greater than the risk of operations performed for carcinoma in the lower portion of the stomach by the abdominal route. Although a large series of cases has not been followed for a period of time sufficient to warrant definite statistics regarding prognosis, it is my impression that the figures will compare favorably with those for carcinoma removed by the abdominal route.

It is interesting to note that most of the work in this field has been done by men who were primarily abdominal rather than thoracic surgeons. I think this is as it should be because the most difficult technical problems of the operation are concerned with resection of the intra-abdominal portion of the stomach and with the establishment of a good anastomosis, procedures for which the abdominal surgeon is particularly qualified.

A series of 57 cases in which the transthoracic approach was employed because of carcinoma of the lower part of the esophagus or cardia forms the basis for this report (table 1).

TABLE 1.—*Transthoracic Operations in 57 Cases.**

	No. of Cases	Hospital Deaths
Exploration (inoperable)	24	0
Resection	33	5†
Total	57	5

*Of the patients 45 were males; 12 females.
†No hospital deaths in last 18 cases in which resection was performed.

DIAGNOSIS

Carcinoma of the cardia of the stomach and carcinoma of the lower end of the stomach produce symptoms that are similar in many cases. Pathologically, they are different, for those carcinomas that arise in the

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esophagus are squamous cell carcinomas and those in the stomach are adenocarcinomas. However, the lymphatic drainage of the lower third of the esophagus is much the same as that of the cardia and the sites of extension and metastasis are similar.

The most common symptom mentioned by patients who have neoplasms in this region is dysphagia. In most of my cases dysphagia has been the major presenting symptom. This may have been present for only a few weeks or for as long as a year. The average duration in the series of cases I have observed was about five months.

The duration of dysphagia is not an accurate indication of the operability of the lesion. I have performed exploratory operations in cases in which there was a history of dysphagia of only a month's duration and have found hopelessly inoperable lesions, whereas in other cases in which dysphagia had been present for more than a year, resection could be accomplished successfully. It should be emphasized, however, that the development of dysphagia in any case demands investigation of the esophagus by roentgenoscopy, roentgenography, and esophagoscopy. The greatest opportunity to cure these patients lies in early diagnosis of presence of the lesion.

TABLE 2.—*Conditions for which Transthoracic Resection of the Cardia and Lower End of the Esophagus was Performed and Associated Procedures: 33 Cases.*

	No. of Cases
Lesions for which transthoracic resection was performed:	
Carcinoma arising in the stomach	27
Carcinoma of the esophagus	3
Benign gastric ulcer	1
Cardiospasm	1
Leiomyoma of cardia	1
Procedures performed in association with transthoracic resection:	
Splenectomy	14
Resection of tail of pancreas	3

Loss of weight is another outstanding sign of this disease. It is caused by inability of the patient to eat rather than by the extent of the malignant growth in most instances. Loss of weight of from 10 to 50 pounds (4.5 to 22.7 Kg.) had occurred in all the patients I have observed. Loss of weight in itself does not constitute a contraindication to surgical treatment.

Other symptoms that have been noted occasionally are hiccup, belching, regurgitation, heartburn, nausea, and vomiting.

Means of accurately diagnosing most neoplasms of the cardia of the stomach and lower portion of the esophagus are readily available. The symptoms suggest the diagnosis; roentgenologic and endoscopic studies are necessary to confirm it. Although it is generally recognized that the cardia of the stomach is the region in which roentgenologic examination is most difficult, there were only 2 cases in the series of 57 cases that I am reporting in which the lesion had not been recognized.

Esophagoscopy is essential because it permits visualization of the lesion and removal of a specimen of tissue from the lesion so that an accurate pathologic diagnosis is possible. In addition, it often provides information as to the exact location and extent of the lesion. Gastroscopy is rarely indicated because the cardia cannot be examined adequately by this means. In the series of cases I am reporting herein, esophagoscopy was carried out in almost every case and a positive diagnosis was obtained on biopsy in most cases before operation was undertaken. Negative findings on esophagoscopic examination should not justify denying a patient exploration, however, if the roentgenologic findings and clinical story suggest the presence of a lesion.

SELECTION OF OPERATION

It is now generally agreed that lesions arising primarily in the esophagus should be approached through the thorax. A few small carcinomas of the lower end of the esophagus have been removed successfully by the abdominal route after the lower end of the esophagus has been mobilized and brought below the diaphragm. The inadequacy and difficulty of such a procedure is obvious.

There is more disagreement about carcinomas of the cardia. Some surgeons have contended that total gastrectomy by the abdominal route is preferable to resection of the cardia and esophagogastrostomy by transthoracic route.

Recently my associates and I have made some studies that indicate clearly the advantages of the transthoracic route. It is well known that carcinoma rarely passes through the pyloric block into the duodenum. Unfortunately, there is no such block at the cardia. Instead, there seems to be a tendency for carcinoma of the cardia to extend along the submucosal layers up the esophagus. Careful pathologic studies and measurements of our specimens have shown that carcinoma of the cardia may extend along the submucosa of the esophagus for several centimeters above the gross lesion. I am convinced that total gastrectomy by the abdominal route will fail to remove the lesion by a sufficient margin in many cases of carcinoma of the cardia. Only transthoracic resection will permit an adequate excision of the esophageal extensions of these lesions.

Dysphagia is the most accurate criterion for determining in which cases carcinoma of

the cardia should be removed by the abdominal route and in which by the thoracic approach. If there is no dysphagia, total gastrectomy performed transabdominally probably will provide adequate excision, but if dysphagia is present, transthoracic resection of the cardia and lower end of the esophagus is essential. As for the risk of the two procedures, I believe it is about the same. In my personal experience, I have done approximately an equal number of total gastrectomies by the abdominal approach and transthoracic resections of the stomach and esophagus; the mortality rate has been almost identical. The disadvantages of the transthoracic approach are that it involves opening both the peritoneal and the pleural cavities and, therefore, offers opportunity for all the surgical complications that can occur in both cavities. Its advantage is that it offers free exposure of the operative site, accurate mobilization of the involved viscera, radical excision of the growth and its associated lymph nodes, and physiologic restoration of the esophagogastric continuity.

PREOPERATIVE MEASURES

Patients selected for tranthoracic exploration of lesions of the lower portion of the esophagus and the cardia of the stomach obviously require a complete and thorough examination to discover, if possible, any extension of the malignant process or other condition that might contraindicate operation. Most of these patients are 40 to 65 years of age, and, therefore, often are afflicted with cardiac, pulmonary, or renal conditions that may increase the hazard of a surgical procedure. Many of these patients are dehydrated, malnourished, and anemic and have vitamin deficiencies by the time they seek help from a surgeon. They should be hospitalized for preoperative preparation with transfusions, parenteral administration of vitamins, and intravenous administration of fluids so that they will be in the best possible condition to undergo the surgical ordeal.

Some surgeons have recommended gastrostomy or jejunostomy to improve the patient's nutrition before they proceed with resection. My attitude has been that if the patient's condition will permit the operation at all, it can be done without this preliminary procedure. Means of providing nutrition in the immediate postoperative period can be accomplished at the time the resection is carried out, if necessary. Preliminary gastrostomy is certainly to be condemned since it will interfere seriously with the mobilization of the stomach at the time resection is undertaken. Preliminary jejunostomy is a more logical procedure, but I object to it for these reasons: (1) It delays the removal of the lesion. (2) Any operation, even a simple one like jejunostomy, takes something out of a patient that is not quickly regained and leaves him a poorer candidate for the major procedure. I avoid staged operations of all types whenever possible. (3) I do not believe that a patient with carcinoma who could not tolerate operation without jejunostomy could be brought into condition for operation by means of a jejunostomy within a reasonable period of time.

It was formerly the custom at the Mayo Clinic to give all patients who were to undergo transthoracic exploration sulfadiazine for several days in sufficient quantity to establish a satisfactory level of the drug in the blood. I am convinced that it was helpful in reducing complications. Since penicillin has been available, it has been used both preoperatively and postoperatively with satisfactory results.

ANESTHESIA

The anesthesia for operations involving thoracotomy is important. Obviously, the first requirement is a skilled anesthetist who has full understanding of respiratory physiology when the thorax is opened. At the clinic an intratracheal tube is inserted routinely after induction of gas anesthesia. Both cyclopropane and ether have been used, but now ether is used routinely. It is possible to administer a higher concentration of oxygen with ether than with any other agent, even cyclopropane, and when one lung is partially collapsed for the length of time that is necessary for transthoracic resection, that is an important factor. Furthermore, there is less oozing of blood with ether than with cyclopropane. The old idea that ether is an irritant and is contraindicated in thoracic surgery is erroneous. Ether is not more irritating than any other inhalation type of agent. I use it routinely for operations on patients with pulmonary tuberculosis.

TABLE 3.—*Causes of Death of 5 Patients.*

Condition	Number*	Days After Operation
Thyrotoxicosis	1	5
Brain abscess secondary to empyema	1	37
Mediastinitis due to leak of anastomosis	1	10
Undertermined	2	4 and 10

*Two deaths occurred after transthoracic total gastrectomy.

TECHNIC

I am unable to see the necessity of abdominal exploration of lesions of the cardia to determine their operability as a preliminary to transthoracic exploration, as has been advocated by Garlock. I am convinced that the operability of a lesion can be determined accurately by the transthoracic route and that

the risk of transthoracic exploration is no greater than that of abdominal exploration. In those cases in which the lesion is operable, preliminary abdominal exploration constitutes an unnecessary burden for the patient. In 24 cases in which I performed transthoracic explorations (table 1) and the lesion proved to be inoperable, there were no postoperative complications and all patients were able to leave the hospital within a week or ten days. From my experience, I believe that primary transthoracic exploration is the procedure of choice in the lesions of the cardia which produce dysphagia.

After the patient is anesthetized and the intratracheal tube has been inserted, the patient is turned so that his right side is down and the left lower portion of the chest is readily accessible. After the operative site has been prepared and draped, a long incision is made along the ninth rib. Subperiosteal resection of the ninth rib is performed. The pleura is then opened. The lung is allowed to collapse partially and is retracted to expose the diaphragm. The left phrenic nerve is readily visualized as it passes over the pericardium. The nerve is injected with procaine to produce temporary paralysis of the diaphragm. The central tendinous portion of the diaphragm is opened sufficiently so that the abdomen can be examined. The entire upper portion of the abdomen is readily accessible to examination and inspection. It is even possible to examine the pelvis.

The extent of the lesion, its attachments and any metastatic lesions can be determined readily. If the lesion is inoperable, the diaphragm is repaired, the lung inflated and the thoracic wall is closed. If the lesion is removable, the incision in the diaphragm is extended to the esophageal hiatus, and the upper end of the stomach and the lower end of the esophagus are mobilized. If necessary, the spleen, the tail of the pancreas, and the diaphragm adjacent to the lesion can be readily included in the resection. The stomach is severed below the lesion and the lower end of the stomach is closed. The esophagus is severed and the lower end of the esophagus and the cardia are removed together. An anastomosis of the end of the esophagus to the anterior wall of the remaining segment of stomach is then performed; two rows of interrupted silk sutures are used for this anastomosis. As much of the stomach as possible is brought above the diaphragm so that there will be no tension on the anastomosis. The stomach is attached to the edge of the diaphragm.

The operative site is washed thoroughly with saline solution. A catheter is inserted in the pleural space for temporary drainage. The phrenic nerve is crushed so that the diaphragm will remain paralyzed until healing has occurred. A catheter is inserted through the nostril and down past the anastomosis into the stomach to provide a means of early postoperative feeding. The lung then is inflated by the anesthetist. The thoracic wall is closed in layers. At the conclusion of the operation, bronchoscopy is performed in order to be sure that the tracheobronchial tree is free of secretion that may cause postoperative pulmonary complications.

POSTOPERATIVE CARE

The patient is placed in an oxygen tent on his return to his room. Usually not more than twenty-four hours of oxygen therapy is necessary. From 500 to 1,000 cc. of blood usually is administered during the course of the operation. Further transfusions are administered during the postoperative period if necessary. The catheter in the chest is connected with a water seal system so that negative pressure is maintained in the pleural space. This permits removal of the pleural effusion that results from the operation and keeps the lung completely expanded. The catheter in the pleural space usually is removed from forty-eight to seventy-two hours after operation.

TABLE 4.—*Complications.*

	No. of Cases
Mediastinitis caused by leak at site of anastomosis	1
Empyema	2
With brain abscess	1
Wound infection (slight)	4
Thrombophlebitis	1
Laryngeal edema (tracheotomy)	1
Thyrotoxicosis	1

A sufficient amount of fluid is administered intravenously to maintain an output of urine of about 1,000 cc. daily until the patient is taking adequate fluids orally. Forty-eight hours after operation water is administered through the tube inserted through the nose and esophagus into the stomach, and seventy-two hours after operation the formula devised for jejunal feeding is given. On the fourth or fifth day after operation the patient is allowed to start drinking water and is placed on a progressive type of diet. By the tenth or twelfth postoperative day, most patients tolerate without difficulty an ulcer type of diet commonly used for ambulatory patients.

Patients are given penicillin in doses of 100,000 units daily by intramuscular injection for one week postoperatively.

Most patients are out of bed by the sixth or seventh postoperative day and are able to leave the hospital on the twelfth to fourteenth postoperative day. It is really surprising to see how little reaction many patients have

from the operation. It is my impression that reaction and shock are considerably less from this procedure than from total gastrectomy. Beecher[2] has reported a similar experience which he attributed to the fact that the transthoracic operation does not require the depth of anesthesia that abdominal operations do and that the exposure is so satisfactory that less pulling of tissues and trauma occur.

There have been surprisingly few postoperative pulmonary complications in these cases. This success may be attributed to several factors: (1) bronchoscopy is carried out postoperatively; (2) postoperative pain and interference from cough are less than after abdominal operations; (3) the depth of anesthesia required for operation is not great; and (4) patients are given penicillin postoperatively as a routine measure.

RESULTS IN THIS SERIES

My experience with the transthoracic approach to lesions of the cardia of the stomach and lower portion of the esophagus is outlined in tables 1 to 4. So far as it has been possible to determine, carcinoma has recurred in 7 of the 33 cases in which resection was performed. This number does not seem higher than is to be expected after any operation for carcinoma of the stomach. In 2 cases stricture developed at the site of the anastomosis and dilatation was required. One patient required pyloroplasty for pylorospasm five months after resection. It has been noted that section of the vagus nerves, which is always necessary, frequently does result in some temporary pylorospasm and delay in emptying the stomach.

Two patients are well three years after resection; 3 are well two years after resection; 2 are well eighteen months after operation; and 12 patients operated on within the last year are well.

SUMMARY

The transthoracic approach to lesions of the lower portion of the esophagus and the cardia of the stomach permits surgical excision of many lesions hitherto inaccessible. This approach is based on sound surgical principles. It provides adequate exposure, permits accurate removal of lesions in this region, and preserves esophagogastric continuity. The transthoracic approach is indicated in all cases of carcinoma of the lower portion of the esophagus and of carcinoma of the cardia in which dysphagia is present.

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THE USE OF PENTOTHAL SODIUM IN THYROID SURGERY

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Pentothal sodium is the most dramatic and the most rapidly acting of any general anesthetic agent that we have at our disposal. It is especially well adapted to use in thyroid surgery.

Pentothal sodium is a product of Abbott Laboratories. It differs from nembutal (pentobarbital sodium) only by the replacement of one of the atoms of oxygen by a sulfur atom on the urea side of the molecule, its chemical name being sodium ethyl (l-methylbutyl-thiobarbituric acid.)[1] There is no absolute proof as to the correct interpretation of the chemistry in the cell that causes the anesthetic effect.[2] The anesthetic effect of pentothal sodium is established by its action upon the central nervous system. As with other useful narcotics, the brain is affected first, the spinal cord next, and the centers of the medulla oblongata last. The rapid action of pentothal sodium is due to the fact that it reaches the nervous system directly from the blood stream before a considerable amount can be destroyed or eliminated.

No physiologist has ever been able to determine the disposition of pentothal sodium after it is injected into the body. Kohn Richards[4] stated that as yet it has not been recovered in any secretion or excretion as such, nor have its break-down products been identified. While one is inclined to believe that sodium pentothal would be destroyed in the liver, recent work by Kohn Richards[3] and other investigators[5] indicate the liver as a place of destruction improbable.

In toxic doses of pentothal sodium, a depression of the respiratory and vasomotor centers in the medulla oblongata occurs.[2] It is believed that anoxemia, if occurring in pentothal sodium anesthesia, is due to the de-

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creased oxygen supply to the lungs following depression of the respiratory centers and not to a peripheral action of the drug upon the oxygen metabolism of the body cells. If a patent airway is secured and the anesthesia is not carried deep enough to interfere with the necessary respiration, no sign of anoxemia should occur. If the operation requires anesthetic levels in which a decrease of respiration cannot be avoided, oxygen administration will obviate anoxemia.

When we first began to use pentothal sodium, we required that it be given by a doctor because it was feared that such a powerful anesthetic agent should not be trusted to nurse anesthetists. It did not require a long period of time for us to realize that pentothal sodium is best given by one who is accustomed to administering anesthetics. Time and use of pentothal sodium have proved that this is correct. Like administering any anesthetic agent, caution, skill, alertness, and practice are required.

FIG. 1. Apparatus for administration of pentothal sodium. *A*, tourniquet; *B*, pentothal sodium; *C*, coramine (Ciba); *D*, 50 cc. syringe; *E*, 20 gauge needle; *F*, three-way stopcock; *G*, 2 cc. syringe; *H*, sulfur free rubber tube; *I*, adaptor to attach 50 cc. syringe; *J*, 15 gauge needle for mixing pentothal sodium and aspirating it into syringe; *K*, sterile distilled water; *L*, medicine glass; *M*, intravenous fluid with connections complete.

Proper preoperative medication is very important. At bedtime the night before operation the patient is given 1.5 gr. of nembutal (Abbott). If the patient is very toxic, this is repeated two hours before operation. Morphine sulfate grains 1/6 or pantopon grains 1/6 and atropine grains 1/150 are given thirty minutes before operation.

We routinely use 2.5 per cent solution of pentothal sodium with one ampule of coramine (Ciba) per gram. Coramine is reported to have questionable value as a respiratory stimulant, but we believe that it has definite value here.

One of the fundamental rules to practice in the use of pentothal sodium is to begin the administration of the anesthetic slowly. Two cc. of the 2.5 per cent solution are injected slowly. The condition of the patient is observed. After a pause of a few seconds the patient is advised to count aloud slowly. On the count of five an additional 1 or 2 cc. are given, and this is repeated on the count of multiples of five. When the patient ceases counting, no more is given until the respirations are regular and the pulse is noted to be regular and full; the jaw muscles are then tested; if they are relaxed, the anesthetic is deep enough for the surgeon to begin. In my opinion this is one of the most important phases of the anesthetic. Too often surgeons are inclined to begin the procedure as soon as the patient ceases counting. If a few additional minutes are allowed the anesthetist at this time, a better anesthetic and a better condition in the patient are assured. Time should be allowed for the respiration to become regular, for a pharyngeal airway to be introduced if needed, and for oxygen to be started. Sufficient time should be allowed for the anesthetist to determine if the pentothal sodium must be discontinued because of conditions such as severe coughing, generalized muscular twitching, vomiting, and severe hiccough. The anesthetist must observe muscle relaxation of the jaw and respiratory rate to determine when more sodium pentothal must be administered. It is a continuous process as is the administration of drop ether.

The apparatus for the administration of pentothal sodium which we have found to be very useful is seen in figures 1, 2, 3, and 4.

It is our practice when pentothal sodium is given for thyroid surgery to begin its in-

jection in the patient's room without his knowing that he is receiving an anesthetic agent. When light sleep occurs he is transferred to the carriage and taken to the operating room where the anesthesia is continued. This procedure has a definite beneficial effect upon the patient as there is no apprehension.

FIG. 2. Apparatus used when no intravenous fluid is needed, consisting of 50 cc. syringe, sulfur free rubber tube, three-way stopcock, 2 cc. syringe, and 20 gauge needle.

Pentothal sodium is well adapted to use in conjunction with other anesthetic agents. It is especially adapted to use with local injection of novocaine.

As a matter of interest I have reviewed the anesthetics used in the last 100 thyroidectomies which we have performed (Table 1). Of these patients 19 received pentothal sodium alone, 46 received pentothal sodium in conjunction with 1 per cent novocaine injected locally; 5 received pentothal sodium and nitrous oxide and oxygen combined; 13 received only novocaine injected locally; 17 received a nitrous oxide, oxygen, and ether combination.

TABLE 1.—*Anesthetics Used in 100 Thyroidectomies.*

Type of Goiter	No. of Cases	Sodium Pentothal	Sodium Pentothal + Local	Nitrous Oxide + Ether	Local	Sodium Pentothal + Nitrous Oxide
Exophthalmic	23	7	9	6	1	
Adenoma, Toxic	44	7	21	6	7	3
Adenoma, Nontoxic	27	4	12	5	5	1
Adenoma, Fetal	3		3			
Carcinoma	3	1	1			1
Total	100	19	46	17	13	5

Study of table 2 will indicate that in those cases in which pentothal sodium was used the pulse was definitely slower at the end of the operative procedure.

When pentothal sodium is used in conjunction with local injection of novocaine, a relatively small amount of pentothal sodium is required. We prefer to use no more than 2 Gm. of pentothal sodium. In cases when more anesthesia is required inhalation of nitrous oxide and oxygen is preferred.

TABLE 2.—*Effect on Pulse of Anesthetics Used in 100 Thyroidectomies.*

Anesthetic	No. of Cases	Average Basal Metabolic Rate	Average Pulse End of Operation	Average High Pulse Postoperatively	Average High Temperature Postoperatively	Day Pulse Returned To 80 or Below
Sodium Pentothal	19	+38	98	110	101.6	3.6
Sodium Pentothal + Local 1% Novocaine	46	+26.6	99	110	101	3.6
Sodium Pentothal + Nitrous Oxide	5	+24.6	85	120	101.6	3.6
Local 1% Novocaine	13	+23	110	109	100.8	3.3
Nitrous Oxide + Ether	17	+32	109	115	101.2	3.3

FIG. 3. Apparatus of figure 2 fixed with adhesive tape to arm and arm board, ready for use.

The recovery time postoperatively is practically the same regardless of the type of anesthesia used. There was no death caused by anesthetic in the cases recorded in the

tables. There was one death in the group. This occurred in a man who had a far advanced adenocarcinoma of the thyroid, and who died evidently of a cerebral metastasis on the second postoperative day.

CONCLUSION

Sodium pentothal if administered properly is safe, and if used with local injection of novocaine is especially useful in thyroid surgery. It relieves the apprehension of the patient. The depth of anesthesia can be altered easily and rapidly. The patient is asleep so there is no straining. The initial pulse rate usually decreases during the anesthesia and the pulse rate during the progress of the operation is not accelerated as much as it is under the other anesthetic agents mentioned. An operative procedure which is often difficult is facilitated. The postoperative reaction is easy: it is more like awakening from normal sleep. For these reasons we consider pentothal sodium anesthesia ideal for thyroid surgery.

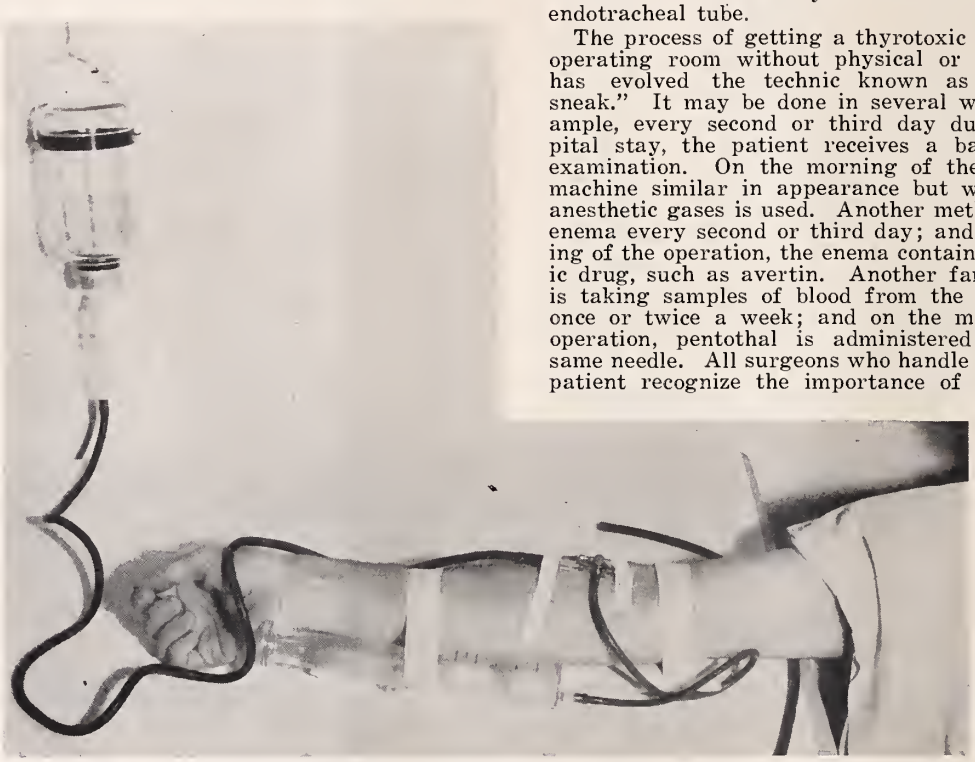

FIG. 4. Apparatus in use with 2 cc. syringe removed and in its place adaptor connecting flask containing intravenous fluid. By turning the stopcock, pentothal sodium or intravenous fluid can be injected into the vein.

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ABSTRACT OF DISCUSSION

Dr. H. C. Slocum, Galveston: Dr. Crump's paper concerning the use of sodium pentothal in thyroid surgery is very interesting. It brings out a technic which surgeons recognize as being necessary for the proper management of patients with thyrotoxic disease. As Dr. Crump has mentioned, the pentothal is given to the patient before being taken to the operating room, thus producing a basal narcosis. Under these circumstances, the basal narcosis of pentothal must be complemented by local infiltration of procaine, the use of gas or ether, or the cocainization of the larynx with introduction of an endotracheal tube.

The process of getting a thyrotoxic patient to the operating room without physical or psychic upset has evolved the technic known as the "thyroid sneak." It may be done in several ways. For example, every second or third day during the hospital stay, the patient receives a basal metabolic examination. On the morning of the operation, a machine similar in appearance but which contains anesthetic gases is used. Another method is a small enema every second or third day; and on the morning of the operation, the enema contains an anesthetic drug, such as avertin. Another familiar method is taking samples of blood from the patient's vein once or twice a week; and on the morning of the operation, pentothal is administered through the same needle. All surgeons who handle the thyrotoxic patient recognize the importance of not upsetting the patient before operation, thus keeping the basal metabolic rate as near a physiologic level as possible.

The barbiturates are hypnotics and differ from narcotics in that pain relief is accomplished only by the production of sleep. This accounts for the fact that pentothal alone cannot be used in operations about the head and neck. In order to obtund the reflex irritability, which is particularly dominant in the neck structures, other drugs and technics must be combined with the pentothal. To aggravate irritable reflexes in any patient, particularly the thyrotoxic patient, is to produce reflex and mechanical obstruction to respiration and abnormal responses of the cardiovascular system which may help to precipitate a thyroid storm or crisis. The high basal metabolic rate indicates the abnormal demand of the tissues for oxygen. Any hindrance to the efficient transportation of respired gases is, obviously, not to be desired.

Sodium pentothal can very well be used in thyroid surgery in the capacity of a basal anesthetic drug. The most important factor necessitated in its use is

the presence of a well-trained anesthetist who is competent in recognizing and facilitating the treatment of the many respiratory and circulatory complications which occur during the course of surgery for thyroid disease.

CENTRAL BONE TUMORS

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The following is a report of some bone tumors which the writer has treated and followed up over a period of years. The results have been uniformly good. There was no question of malignancy except in 1 case and even that was diagnosed as benign by the pathologists at the time of operation. The radiologist insisted that it was an osteogenic sarcoma and most of the pathologists have since come to regard it as malignant. The patient elected amputation in that case and it would now appear that this was fortunate in view of the changed pathological diagnosis and the excellent result obtained. In all other cases the treatment was conservative. The tumors were adequately exposed by removal of cortical bone, meticulous curettage was done, and the cavity walls were carefully gone over with the cautery, either actual (heat) or chemical. Autogenous bone grafts were used in 1 case to expedite the filling of the bony defect.

CASE REPORTS

CASE 1.—*(Giant Cell Tumor).*—J. C. F., a white man, aged 30 years, single, a farmer, gave a history of a small, painful area on the anterolateral aspect of the right thigh. He had received a kick from a mule at that point about one and one-half years before admission to Baylor Hospital. The injury had not appeared to be serious at the time and the soreness had largely disappeared after a few days, a slightly tender spot about the size of a 25-cent piece remaining. For the past year he had noticed increased pain there and had felt a hard swelling beneath the muscles in that area. Aspirin afforded him relief. Examination disclosed an indurated swelling at the point of complaint, the anterolateral side of the right thigh, middle third.

The roentgenograms disclosed a semifusiform enlargement on the lateral side of the femur, the proximal and distal portions of which were of compact new-formed bone with a central rarefied area. This latter did not appear to penetrate the marrow cavity and measured .625 by 1.25 inches. The radiologist called the lesion an "old periostitis . . . with bone abscess," suggesting the possibility of a typhoid infection to which some credence was lent by a history of "walking slow fever" some twelve years before admission.

Operation was done May 17, 1923. The soft parts were incised directly over the mass and the outer layer of compact bone was removed with osteotome to expose the tumor, which was largely of soft tissue. The contents of the bone pocket were carefully curetted and the thermocautery was applied to the limiting walls. It was used primarily to check bleeding from a small artery in the bone. Recovery was uneventful and the patient was free of symptoms upon discharge from the hospital.

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The microscopic findings as reported by Dr. George T. Caldwell were as follows:

"The mass consists of numerous bony spicules between which there is a relatively abundant fibrous tissue containing many gaint cells of myeloid type. The giant cells vary moderately in size and shape, but are predominantly small. The stroma is relatively mature and mitotic figures are few. Pathological diagnosis: Giant cell tumor, benign type."

A recent letter states the patient has been quite well for twenty-two years. Roentgenograms made

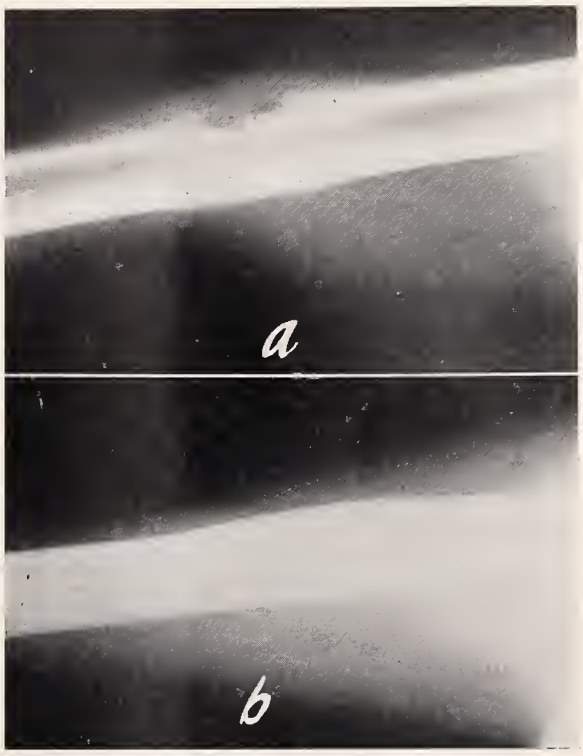

FIG. 1*a*. Giant cell tumor of shaft of femur at site of mule kick (Case 1).
b. Same area of femur twenty-two years after operative cure.

June 29, 1945, disclosed no evidence of the tumor, some increased density in the area formerly occupied by it.

The diaphysis is an unusual location for a giant cell tumor, as such tumors are commonly found in the epiphyseal ends of the long bones. That fact, together with the development of this tumor within a semifusiform mass of new-formed bone along the femoral shaft, leads one to speculate on the possibility that this tumor may have developed at the site of a subperiosteal hematoma (traumatic from mule kick) which had resolved itself by new-bone proliferation.

CASE 2.—*(Xanthoma.)*—B. B., a white boy, was 13 years old at the time of operation. The lesion was situated in the proximal end of the tibial diaphysis, which is quite unusual, and was further remarkable in that the clinical symptoms were largely in the neighboring knee joint where no roentgen evidence of the disease was found, and the symptoms disappeared following extirpation of the tumor.

This patient was under observation at the Freeman Memorial Clinic for over three years before consent to operate was obtained. On his admission, the chief complaint was swelling of the right knee joint with mild soreness. Some 25 cc. of "serous, slightly turbid, straw-colored fluid" was aspirated

from the joint and a diagnosis of "synovitis of right knee with serious effusion" was made. A few weeks later, the boy was referred to the orthopedic department where it was noted that there was 1 inch of swelling (circumference measurement) with slight excess fluid in the joint. The roentgenograms disclosed an area of rarefaction in the right tibia 1.5 inches distal to the proximal epiphyseal line. This area was ovoid in shape, measured .625 by 2 inches, and was situated in the lateral half of the bone where the cortex of the tibia appeared thinned out and bulged somewhat toward the fibula. The margins of the area were irregular but well defined and some fine trabeculation was noted within. A tentative diagnosis of giant cell tumor or bone cyst was made.

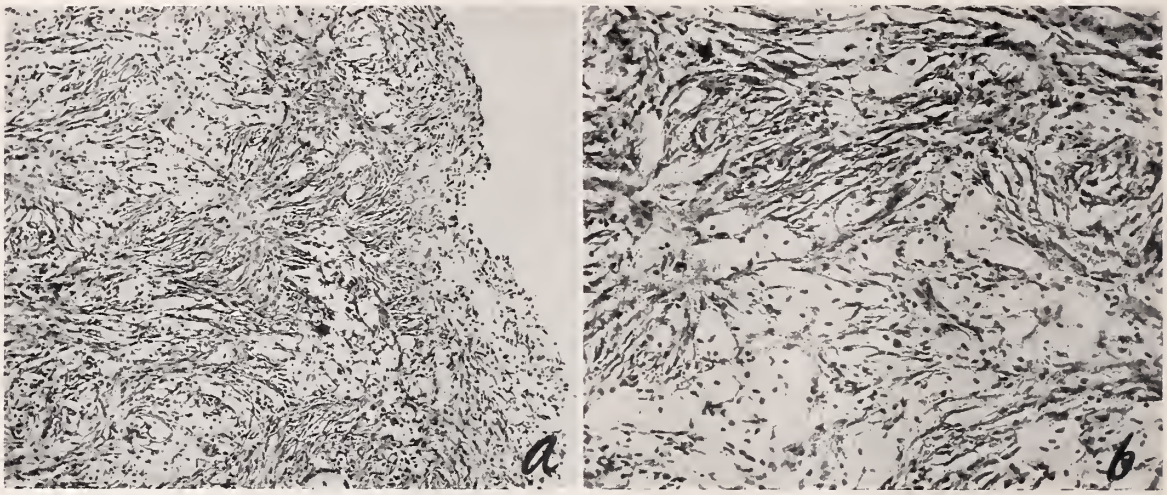

FIG. 2*a*. Low power view showing a fibrous tissue stroma consisting of fibroblasts among which many "foam" or xanthoma cells are located (Case 2).
b. High power view of same microscopic section.

Further observation during succeeding months disclosed only mild swelling of the knee joint with some exudate present. The patient complained very little. Roentgenograms after two and a half years showed no increase in vertical length but some increase in breadth of the lesion, which had extended across the bone marrow into the medial side of the bone. A recurrence of the knee swelling was noted a few days before operation.

Operation was done on October 29, 1928, at Parkland Hospital. Incision was made just lateral to the tibial crest, the muscles being reflected to expose the bony cortex, which was removed with osteotome to uncover the tumor. The tumor tissue was described as grayish, soft in consistency for the most part but containing some thin bony trabeculae which afforded slight resistance to the curette. Thorough curettage was done followed by the application of the thermocautery to the limiting walls.

The pathological report as made by Dr. J. L. Goforth was as follows:

"This tissue grossly has a buff yellow appearance and is so granular in several instances that it gives the picture of necrotic tissue . . . The picture grossly is not that of giant cell tumor. Several sections through different pieces of tissue give a constant picture which is not that of giant cell tumor. The stroma is composed of fibroblasts, some mature, others relatively immature. Scattered throughout this rather dense stroma many foam or xanthoma cells are noted. They occur singly, in strands, and in patches. These cells possess tiny deeply-staining nuclei and have abundant granular, 'foamy' cytoplasm. Epulis gaint cells are not present. Blood pigment is noted in patches. This tumor is considered to be of low-grade malignancy and is not likely to metastasize. It will not recur locally if completely removed. Pathological diagnosis: Xanthoma of the leg, origin not determined."

Recovery following operation was uneventful. Roentgenograms showed that the bony defect had practically filled in with new-formed bone at the end of a year. No recrudescence of symptoms was experienced. Last seen on July 26, 1943, the patient reported himself as entirely free of symptoms and roentgenograms of the same date disclosed no evidence of the tumor, only slight increase of bony density at the level of the old lesion.

CASE 3.—*(Enchondroma)*.—Mrs. E. F., a white woman, aged 42 years, married, housewife, gave a history of a swelling on the medial side of the right tibia which had existed for several years with gradual increase in size. There had been no pain at first but it began some eleven weeks before admission to St. Paul's Hospital. The pain had not been great. The patient had received an injury to the right ankle at the age of 6 years which had left her with a considerable valgus deformity, but her idea of a connection between that and the present trouble appeared rather far-fetched.

Examination disclosed a hard, bony swelling on the medial side of the right tibia beginning just proximal to the ankle joint and ranging proximally for about 2 inches. Roentgenograms disclosed an irregularly oval area of bone destruction within the tibial shaft, beginning .5 inch proximal to the ankle joint and extending proximally for 2.5 inches. It was 1.75 inches wide at its greatest width. The surrounding bony wall was rough and irregular with a bulging medially where it appeared quite thin.

Operation was done May 7, 1932. Exposed subperiosteally, the cortical bone was removed with osteotome for wide exposure. The tumor tissue was found to be whitish in color and semisoft in consistency. Thorough curettage was done. A small area where the bone had been eroded down to the periosteum was found near the proximal end of the cavity on its posteromedial aspect. The marrow cavity was found to be sealed over with a bony bridge at the proximal pole of the tumor cavity. A pocket measuring .125 inch in diameter was found along the lateral wall of the cavity, covered over by a thin bony partition which was removed. The

pocket was elongated proximally for .5 inch beyond the limiting bony bridge across the marrow. It was thoroughly reamed out. Phenol was used as a cautery followed with alcohol. A bone graft was taken from the tibia nearer the knee and this was used to help fill the cavity left after removal of the tumor. The cortical bone removed for exposure of the tumor was also used for the same purpose, care being taken that all tumor was removed and phenol applied to its inner surface. The thermocautery was applied to the space from which the graft was removed for the dual purpose of control of a

Fig. 3*a*. Anteroposterior and lateral views of the ankle region, chondroma (Case 3).
b. Views of same area nearly thirteen years after operation.

bleeding vessel and prevention of possible tumor cell implantation. A "rubber dam" was used as a drain. The patient was discharged from the hospital on May 14, wearing a leg brace.

The pathological examination was made by Dr. J. L. Goforth who reported as follows:

"Specimen consists of a large quantity of friable, cream-colored tissue. . . . Sections through several pieces of tumor all show the same general histologic picture. There exists a fairly homogeneous, acellular, hyaline matrix which shows rough fibrillation in places, stains pinkish-blue, and resembles imperfectly formed or immature cartilage. Throughout this matrix, scattered cells are seen. Sometimes they appear as varying sized and shaped stellate cells irregularly placed in the matrix; again they occur in pairs in small pockets in the tumor matrix with their opposed surfaces flattened. These latter cells have the appearance of cartilage cells. In a few places small, irregular patches of connective tissue which tend to trabeculate the tumor to some extent are seen. Scattered mononuclear cells, lymphocytes chiefly, and blood vessels are seen in these areas. Pathological diagnosis: Primary chondroma of lower end of right tibia (enchondroma), locally destructive and capable of recurrence."

Dr. Goforth further commented:

"It is relatively acellular and apparently has grown very slowly by the process of peripheral expansion. . . . In its present form, the tumor is not likely to metastasize. It is quite likely to recur locally in event it has been incompletely removed and a recurrence is likely to grow more aggressively than the original tumor. Also true malignant behavior may be assumed in event of a recurrence."

This patient was seen from time to time for several years and roentgenograms disclosed no evidence of return of the tumor. The cavity gradually filled in with new-formed bone. The family physician reported her as well on March 6, 1945, and roentgenograms of that date showed no evidence of recurrence, only some areas of uneven density, probably the result of the bone grafts.

Case 4.—*(Bone Cyst)*.—Mrs. L. G., a Mexican woman, aged 28 years, maid, gave a history of a mild aching type of pain in the proximal half of the left arm which had followed accidental injury several years before admission to St. Paul's Clinic. Examination disclosed local tenderness with complaint of pain upon full abduction of the left arm. Roentgenograms made twenty-two months before operation showed that the left humerus was the seat of a destructive lesion extending from a point within the head .5 inch beyond its articular surface, distally into the diaphysis for 6.5 inches. The rarefaction was inside the cortex, which was markedly thinned-out in appearance. One-half inch proximal to the distal limits of this internal erosion, the cortex

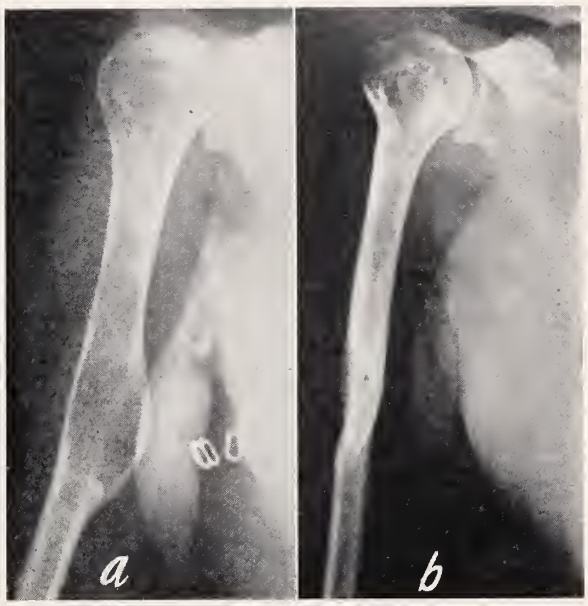

Fig. 4*a*. Views a few days prior to operation of the lesion in Case 4 diagnosed pathologically as bone cyst.
b. Same humerus seven years after operation.

bulged in the direction of the axilla for .5 inch and over a length of 2 inches. Within this bulge as well as in the capital portion of the lesion, thin bony septae appeared. Roentgenograms of a few days prior to operation disclosed much less trabeculation within the lesion, which occupied the same area as before.

Operation was done at St. Paul's Hospital on May 5, 1938. Incision was made over the proximal part

of the left arm by "splitting the anterior margin of the deltoid muscle." This was extended distally as far as the lesion reached. A slit-like opening was made in the cortex of the humerus to uncover the

FIG. 5. Anteroposterior view of tumor of femur. Marked destructiveness of lesion is quite apparent (Case 5).

diseased area. A soft, pulpy tissue was curetted from within the shaft and head of the bone followed by the use of phenol as a cautery neutralized with alcohol. The wound was closed without drainage.

Dr. Goforth examined the tissue removed and reported as follows:

"Several sections made through the different pieces of soft tissue all show fibroblastic tissue representing various stages of repair. Frequently patches of totally degenerated hemorrhagic material are noted. None of the sections reveals a picture characteristic of giant cell tumor of bone, and likewise the general picture is not that of osteitis fibrosa. The sections reveal no evidences of neoplasia or of a specific infection of any kind. From the histologic viewpoint the condition is regarded as a bone cyst which contains degenerated and regenerated soft tissue elements. Now that the cyst is broken, repair activity should continue with the osteitis fibrosa picture predominating. Pathologic diagnosis: Benign bone cyst, left humerus."

This patient went on to recovery and has been well ever since. Last seen on May 24, 1945, she reported herself as quite well. Roentgenograms made on that date disclosed the cloudiness of increased density of bone in the diaphysis with no evidence of recurrence of the lesion. Within the head of the humerus the density was the same medially, but laterally a small area of decreased density was noted.

CASE 5—*(Sarcoma)*.—C. T. W., a white man of Danish birth, aged 68 years, married, gave a history of a fall thirteen months before admission to Parkland Hospital. The region of the left knee joint was injured but the symptoms were mild and he thought he had recovered after two or three months. About eleven months after injury, he began to have pain and swelling, the pain being greater when he walked. Those symptoms had gradually increased and the patient described the pain as throbbing in character. Examination disclosed marked swelling of the distal part of the left thigh and knee joint region; the swelling was described as somewhat "indurated." Tenderness was not great but flexion of the joint was quite limited.

The roentgenograms disclosed a markedly destructive lesion of the left femur involving the distal 6 inches of the diaphysis. Only a thin rim of cortical bone remained in but a few places and this appeared to be pushed out peripherally to a width of 4 inches by the expanding lesion within. Dr. P. E. Wigby, the radiologist, described it as of "a cystic appearance" and thought the tumor to be an osteogenic sarcoma.

Material for biopsy was removed with the thermocautery and two pathologists, Drs. C. B. Sanders and J. L. Goforth, examined it independently, each giving a diagnosis of gaint cell tumor.

The problem that now posed itself was how best to dispose of this tumor. Here was an elderly but vigorous man. It was explained to him that if the tumor could be removed completely and followed with a heavy bone graft, he would probably recover after a prolonged convalescence. As an alternative, amputation offered the hope of quick recovery, provided that he could survive such a procedure at his advanced age. Without a moment's hesitation, he said: "Take it off."

Amputation at the middle of the thigh was done on July 30, 1935. Most of the operation was done with local use of novocaine solution, a little gas being given while the femur was sawed through. In

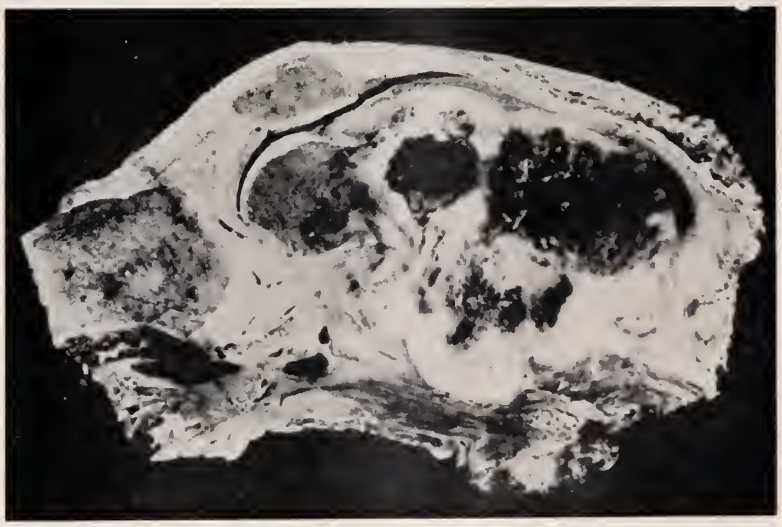

FIG. 6. Photograph of frozen and bisected distal end of femur and knee region after amputation (Case 5).

spite of these precautions, he was in only fair condition at the end of the operation and stimulation was required for a few days. Thereafter recovery was satisfactory.

Both pathologists made studies of the tumor after amputation and confirmed their previous diagnosis

of giant cell tumor. The report of Dr. Sanders follows:

"Gross: Left leg is amputated in mid-portion of the femur. There is a rounded tumor mass just proximal to the knee joint which has completely destroyed the shaft of the distal half of the femur. The tumor is well circumscribed and there is a definite line of demarcation between tumor and surrounding muscle and soft tissue. The tumor is extremely cystic, containing cavities measuring from 1 cm. to 8 cm. in diameter which are filled with a necrotic yellow exudate. There are some spicules of bone scattered throughout tumor. There is a large amount of hemorrhage and hyperemia in the tumor mass. Portions of tumor are firm and gray and show hyaline change. Microscopic: The tumor consists of interlacing bands of spindle cells in which there are many gaint cells containing from eight to twenty nuclei. There is extensive degeneration and necrosis in the tumor. There are numerous small areas of normal appearing bone scattered throughout the tumor. There is no definite evidence of malignancy. Pathological diagnosis: Benign giant cell tumor of distal portion of the femur."

The radiologist insisted that the tumor was malignant and sections of it were sent to Dr. J. C. Bloodgood. Since he was on vacation his associate, Dr. L. C. Cohn, acted for him. The latter reported that he was unable to give a definite diagnosis but suggested three possible ones, osteitis fibrosa, giant cell tumor, or sarcoma. He further commented: "This is not a simple case for diagnosis. I can't be certain whether this is a variant of a giant cell tumor, in which there are no areas in which the giant cells are numerous enough to say they predominate, or whether it is an area of osteitis fibrosa, or a low grade osteogenic sarcoma. Sixty-eight is not the age for osteitis fibrosa. The predominance in some places of spindle cell stroma also suggests the possibility of a nerve sheath tumor, with secondary involvement of bone." Dr. Cohn was quite interested in the outcome and kept in touch with us, finally asking for the roentgenograms. He studied these in connection with the sections in February, 1938, and reported: "The tumor is essentially composed of spindle cells in a myxomatous stroma and I now look upon this tumor as a neurogenic sarcoma secondarily involving the bone."

This case was reported before the Dallas County Medical Society in 1943. Present was Col. Bradley L. Coley, M. C., A. U. S., who became interested and sent some microscopic sections as well as roentgenograms to Dr. Fred W. Stewart, of New York City. The latter's diagnosis as relayed to me by Dr. Coley was that of fibrosarcoma.

The patient remained well until his sudden death on February 12, 1944. He had been seen from time to time and occasional roentgenograms were made of the amputation stump and chest but no evidence of recurrence or of metastasis was noted up to the final roentgenograms made on July 27, 1943. He had lived for over eight and one-half years after amputation. This case was most interesting and considerable difference of opinion among the pathologists, not to mention the radiologist, has been noted.

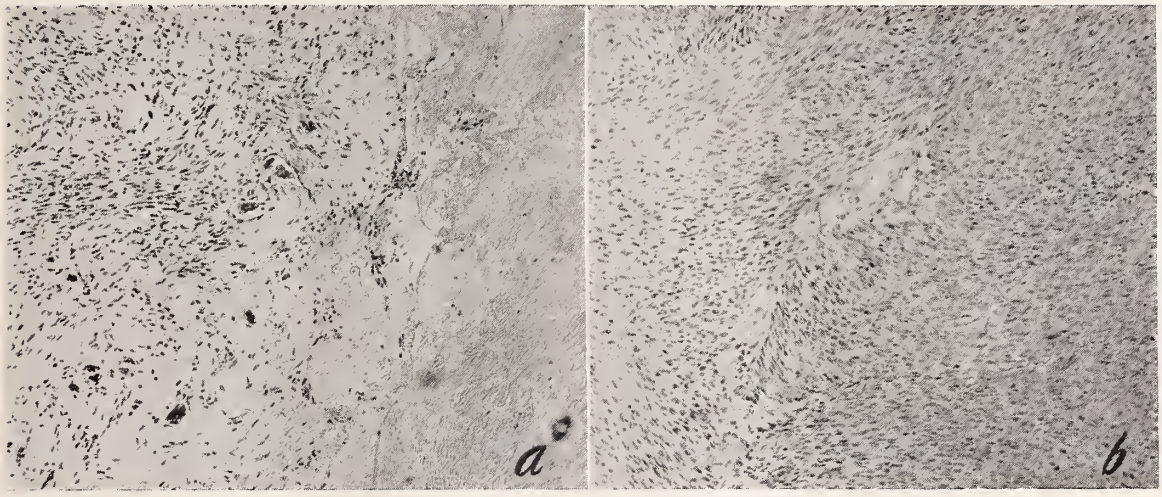

FIG. 7*a*. Low power view showing fibroblastic stroma in which scattered epulis giant cells are located (Case 5).
b. Low power view showing dense cellular fibroblastic tissue composed of spindle shaped fibroblasts. Scattered mitotic figures are noted in these cells. (Case 5).

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UNRRA EMERGENCY MEDICAL STOCKPILES

A stockpile of vaccines and biologicals, as well as water purifying equipment, is being built up in London by the United Nations Relief and Rehabilitation Administration to be ready to combat possible outbreaks of epidemics, the agency's Washington headquarters has announced.

The reserve stock of supplies is being acquired from sources both in the United States and the United Kingdom.

Arrangements have been made for packaging the supplies so that they can be shipped by air and thus can be flown immediately to the scene of any outbreak of disease in countries where the agency operates. Because London is close to most of these countries, the stockpile is stored there.

Included among the supplies are diphtheria antitoxin, toxoid, and Schick test toxin; smallpox vaccine; tetanus antitoxin; and vaccines for use against plague, typhus, and gas gangrene.

The purifying equipment includes twenty-four portable gasoline engines with hypochlorinating units capable of processing fifty gallons of water per minute for drinking and hospital purposes as well as a dozen other purifying outfits. All these units also are capable of shipment by air.

THE MANAGEMENT OF NONSPECIFIC URINARY TRACT INFECTIONS

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The management of urogenital infections should be based upon knowledge of a few well recognized precepts. Departure from these fundamentals usually leads to failure.

Such general measures as adequate nourishment and rest, transfusions, necessary sedation, and other procedures that contribute to the comfort and improve the general well-being of the patient are utilized in both the preventive and active phases of the treatment.

Timely prophylaxis often minimizes the need for active therapy. One should exert every effort to avoid or correct obvious predisposing factors.

The principal active therapeutic measures may be grouped under four major headings—the four "D's": diagnosis; drainage; dilution; drugs.

DIAGNOSIS

Accuracy and completeness in diagnosis exerts a profound influence upon the response of the infection to the various procedures which may be employed to control it.

It is elementary to comment upon the importance of a carefully elicited history. Those who are well acquainted with the vagaries of urinary symptoms, the "silence" of some serious pathologic processes, the frequent reference of symptoms to other systems (notably gastro-intestinal), and the insidious progress of some lesions realize the ease with which pertinent data may be glossed over or omitted by the patient and its significance misinterpreted by the physician. Careful questioning and review should not be neglected.

Although urologic diagnostic technic has become highly specialized, much must first be learned through a simple routine physical examination. This includes a survey of the patient's general physical status as well as local urologic study. Debility, malnutrition, anemia, diabetes, serious cardio-renal disorders, and other general diseases may exert considerable effect upon prognosis, progress, and therapeutic endeavor in urogenital infections. A general estimate of the type and extent of involvement of the urogenital system is essential to sound judgment in selection of diagnostic and therapeutic measures. For example, instrumentation in the face of acute urinary infections is contraindicated until proved unavoidable because of the danger of inducing a generalized bacteremia or septicemia. Furthermore, many chronic infections cannot be eradicated or controlled until certain accessory factors such as obstruction, trauma, foreign bodies, and bacterial or chemical toxins are detected and removed.

The laboratory is a valuable diagnostic ally. Much may be learned from gross inspection of the urine, particularly if it is voided continuously into two clean glass containers and observed with the "mind's eye" trained upon the pathogenetic probabilities. The urine specimen should be collected in as aseptic manner as possible. For practical purposes the second portion of a voided specimen in the male is suitable, but in females a catheterized specimen is almost essential. The container should be sterile if cultures are to be done and examination must be performed while the urine is fresh.

Bacteriological study of the urinary sediment is routine. Stain by the Gram method is suitable for all practical purposes, since it will determine whether the infecting organisms are predominantly bacillary or coccal and gram-negative or positive. Cultures may be resorted to when indicated.

The status of renal function should be appraised. The phenolsulphonphthalein excretion test and estimation of blood nitrogen retention seem to be the most uniformly dependable at the present time.

Urography is an important part of the detailed study of the urinary tract. Excretory urograms are commonly used; however, because of their inherent limitations, it is often expeditious, unless contraindicated, to proceed initially with retrograde urograms. In this manner one may at once obtain visualization of the urethra and bladder, study differential renal excretory function, explore the ureters with catheters, obtain separate specimens of urine from each kidney pelvis for examination, and secure a more clear cut urographic delineation of the urinary tract by retrograde injection of radio-opaque media.

Cystoscopic and similar instrumental examinations are best employed by the trained cystoscopist. Accurate interpretation of endoscopic findings is dependent upon judgment gained through relatively extensive guided experience.

DRAINAGE

It is universally recognized that urinary stasis definitely encourages the occurrence or persistence of urinary infection. Promotion of drainage in a suitable manner therefore

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is a logical requirement in control of such infections.

The presence and degree of obstruction must be evaluated. Each case must be judged and handled individually, but brief mention of some of the methods is timely.

Meatotomy is a simple procedure employed too seldom. We have observed frequent instances in which a stubbornly resistant urethritis or prostatitis of specific or nonspecific origin cleared up promptly following adequate meatotomy.

Judicious urethral dilation with sounds and bougies is practically a tradition. It may be used selectively to promote drainage from urethral glands, the prostate, and seminal vesicles. Legitimate increase in the caliber of urethral stricture also enhances expulsion of urine from the bladder and reduces adverse effect on the prostate. Rarely now do urethral strictures require internal or external urethrotomy.

Drainage of the urinary bladder pending the surgical correction of vesical neck obstructive lesions is ordinarily secured either by indwelling urethral catheter or suprapubic cystostomy. We most frequently employ Foley type retention catheters of small diameter (F 16 to 18). They are better tolerated during introduction, sojourn, and removal than other types. In some instances it is necessary to hold other types of catheters in place with strips of adhesive tape. Our cystostomies are performed by the trocar and canula technic and the catheter which is threaded through the canula is secured by loops of silk through the skin until it can be replaced by a Foley catheter. Interval catheterization is advocated by some. Indwelling catheters draining continuously through a closed system have proved more generally satisfactory in our hands. Aseptic principles must be observed and the catheter changed weekly if drainage is prolonged.

Postoperative urinary retention may provide a nucleus for infection. We have had no success yet with parasympathetic stimulating drugs. Careful catheterization still seems to be the treatment of choice. One must observe strict asepsis and avoid trauma of over-distention or rough instrumentation. Following extensive rectal or pelvic surgical procedures, the use of a small indwelling Foley retention catheter attached to a closed irrigation system for a variable period of time has become a routine.

Drainage of the ureters and kidney pelves is most commonly accomplished via ureteral catheters. Periodic dilatation sometimes will suffice. In most instances when their retention is necessary or desirable our practice is to leave them in place for seventy-two hours and replace them later if required. Pyelostomy and nephrostomy are occasionally necessary. Extrinsic obstructions, such as aberrant renal arteries, adhesive bands, various intra-abdominal tumors, and kinks due to renal ptosis, all require surgical intervention.

Frank suppurative lesions that are enclosed or drained inadequately require ample surgical incision and drainage. Occasionally complete removal of an organ so affected is the most conservative procedure.

DILUTION

Dilution of bacterial toxins and relative reduction in the number of bacteria is obtained by a large fluid intake and augmented urinary output. If oral intake is insufficient, it must be supplemented or replaced by suitable parenteral administration.

The body defensive mechanisms are better able to combat and overcome the infection when the bacterial count is thus relatively reduced. Helmholz has shown that bacteria may be susceptible to certain chemotherapy when their concentration is low but when present in overwhelming numbers no bactericidal effect is discernible.[3]

DRUGS

The intelligent administration of drugs to combat urogenital infections now requires identification of the causative organisms, estimation of the degree and extent of infection, appraisal of kidney function, detection of any accessory complicating factors and determination of idiosyncracies. Recent knowledge emphasizes selective action in chemotherapy.

Before sulfonamides were added in 1936 to the now imposing therapeutic armamentarium, these factors were of relatively little importance. A host of remedies was used prior to this time. Alkalies and acidifying agents were given, depending upon the reaction of the urine. Methenamine held the spotlight for many years and it is still employed in selected instances.

In 1931 the ketogenic diet was advocated and utilized for production of bactericidal quantities of betaoxybutyric acid in the urine. It has yielded to mandelic acid, which Rosenheim introduced in 1935, as an effective inhibitor of urinary bacterial growth because mandelic acid is more available, more economic, and more pleasant to take.[4]

We administer calcium mandelate tablets in sufficient dosage to secure a urinary *p*H 5-5.5. The average dose for adults is about 3 Gm. every six hours, but experience has taught that this must be varied according

to individual tolerance and the hydrogen ion concentration of the freshly voided urine as determined by frequent testing with nitrazene paper. Sharp restriction of fluids may be necessary. Gastro-intestinal irritation and hematuria may be unpleasant side effects. Its bactericidal efficacy is nullified by insufficient excretion due to marked impairment of renal function or by some strongly alkaline infections. Carroll has recommended the intravenous administration of specially prepared sodium mandelate solution to avoid gastric irritation.[2]

The sulfonamides are the most universally useful urinary bactericides. Clinical experience indicates that sulfathiazole is the best of the sulfa-derivatives for this purpose since it controls or prevents most simple urinary infections except those caused by Streptococcus faecalis. Mandelic acid therapy is ordinarily effective for the latter. Relatively small doses are employed both prophylactically and actively, ranging from 0.5 Gm. every four to six hours to 1.0 Gm. every six hours. Adequate fluid intake is insured by insisting that the patient "drink a gallon of liquid a day" or by supplementing with intravenous fluids. Alkalies are given to minimize the danger of excessive acetylization with crystallinuria.

Since the response is not always uniform, it may be necessary to change to sulfadiazine, sulfamerazine, or sulfacetamide in attempting control of an infection. We have found sulfacetamide particularly useful in pyelitis of pregnancy.

Succinylsulfathiazole has proved almost indispensable in preparation for ureterointestinal implantation and for control of infection following it. Postoperative febrile reaction is now rare. Dosage is calculated on the basis of .25 Gm. per kilogram body weight per day.

Unfortunately the sulfonamides are not without danger since some patients exhibit definite idiosyncracy to these drugs, and three types of extremely serious renal damage are recognized: (1) frank obstruction by crystals; (2) widespread focal necrosis including the kidney; and (3) acute toxic nephritis.[8] These dangers are minimized by small doses plus adequate fluid intake plus alkalinization. Routine estimation of blood levels is not considered necessary in the program outlined above.

In some instances of pure staphylococcal infection which resisted treatment by other methods, we have observed dramatic response to the intravenous injection of small doses of neoarsphenamine (0.3-0.4 Gm.) every five days for eight doses. Arsenicals also seem to be more or less specific for "true infective abacterial pyuria."[1, 7]

The use of various instillations and irrigations is of doubtful value. The chief benefit that is derived from the various solutions seems to be mechanical cleansing and perhaps reduction of the intensity of the infection by dilution. Stone dissolving solution "G" developed by Suby, Suby, and Albright is nonirritating and acid in reaction. It may be employed effectively in certain alkaline type infections,[9] notably alkaline encrusted cystitis.

Pyridium and serenium seem to exert mild antiseptic action in the urine and often prove soothing to the inflamed tissues. We usually give two tablets three times daily. The patient should be forewarned of the color change that will occur in the urine.

Penicillin is such a recent addition that sufficient clinical experience has not accumulated for true evaluation. The optimum in dosage, mode, route, and frequency of adminisitration is not yet established. A few toxic reactions such as urticaria, vesicular eruptions, abdominal cramps and localized thrombophlebitis have been reported, but no serious side effects have been demonstrated.[6]

The dramatic effectiveness in rapid cure of gonorrhea is well known. In nonspecific urethritis, significant improvement is not the rule, and physicians must still rely upon periodic massage and urethral sounding as the fundamental basis of treatment.

Reported susceptibility of Staphylococcus aureus, Streptococcus faecalis, and Proteus ammoniae offers therapeutic promise. Our endeavors to control urinary infections with penicillin have been disappointing. Gram-negative bacillary invaders are quite resistant.[5, 6]

The intramuscular administration of relatively large amounts of penicillin in frequent divided doses pre- and postoperatively has in most instances simplified the handling of serious staphylococcal suppurative lesions in the kidney and perinephric space. Reports indicate a decided reduction in morbidity and mortality and less need for radical surgical procedures. We are not yet convinced of the advisability of neglecting fundamental surgical drainage, however.

The early reports regarding streptomycin are encouraging. This is another of the antibiotics produced by soil actinomycetes. Experimental evidence to date indicates that it may be of practical usefulness in control of infections caused by various gram-positive and gram-negative organisms and may even be inhibitive to human strains of Mycobacterium tuberculosis.[10, 11]

CONCLUSION

The advance in development of agents for control of urogenital infections has been rapid during the past ten years. Neglect of fundamentals usually results in failure. The four "D's" are diagnosis, drainage, dilution, and drugs. Each has a place in the intelligent management of urinary tract infections.

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HOSPITALIZED VETERANS OFFERED COURSES

Arrangements to provide educational opportunities through the United States Armed Forces Institute for personnel in veterans hospitals has been announced by the War Department.

Some ninety-odd correspondence and self-teaching courses prepared by the USAFI will be made available to hospitalized veterans in accordance with arrangements made with the Veterans Administration. The courses will be followed up by corresponding end-of-course tests such as are regularly given to personnel on active duty.

The Veterans Administration has planned that lessons and tests submitted will be graded by the University of Wisconsin, which now grades lessons submitted by military personnel. Registration of courses, grading of lessons, administration and grading of tests, and the recording of course completions for possible accreditation purposes will be the complete responsibility of the Medical Rehabilitation Service of the Veterans Administration. The Army supplies at one time bulk shipments to named veterans hospitals.

Generally, personnel in veterans hospitals have been unable to participate in educational programs. Such personnel could not enroll for USAFI services, which are limited to military personnel on active duty or to certain veterans who had enrolled for courses prior to discharge. On the other hand, veterans could not take advantage of educational programs provided for them until they had been separated from the veterans hospitals. Therefore, this new arrangement is limited to hospitalized veterans. —S. G. O. Notes, March 31, 1946.

THE USE AND ABUSE OF SULFONAMIDES IN DERMATOLOGIC CONDITIONS

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Since the sulfonamides have been introduced into medicine many lives have been saved, and the course of many illnesses shortened. They form a valuable addition to our therapeutic armamentarium. The indications for their use are well described, the method of their employment is well standardized, and their limitations are well known. The purpose of this discussion is not to depreciate their value, but to plead for their conservative use and to warn against their untoward effects, particularly with reference to prevention of the eczematous reactions.

There are several dermatologic conditions which call for the employment of one or the other of these products. In some of these conditions greater dependence is placed upon the drug than upon any other procedure used concomitantly; in others, the use of the drug is as an adjuvant, or it may be discretionary.

There is no skin condition in which the local use of sulfonamides for a period longer than four days is justified. This will be elaborated upon later, and furnishes the theme of this paper.

ADVANTAGES OF THE DRUGS

The conditions in which the use of the drugs are of definite value comprise certain nonsyphilitic venereal diseases and acute pyogenic infections. Of the venereal diseases, lymphopathia (lymphogranuloma) venereum and chancroid call for their use. The results in each are of course best when the drugs are used in the early stages. In a series of cases of lymphogranuloma treated by Kennedy and others,[6] reported in 1941, the acute cases were cured in an average of thirty-four days, and the chronic cases in an average of forty-eight days. F. C. Combes, Canizares, and Landy[3] in a study of 97 cases of chancroid treated with sulfathiazole estimated the time for cure of simple cases as five days and for those complicated with buboes as of seven days. The average amount of the drug required was 21 Gm. for the simple cases and 29 Gm. for the complicated. It has been reported that a positive Frei test became negative after treatment with the drug, thus indicating a specific effect upon the infection. Gonorrhea is preferably treated by penicillin; however, in the rare cases of penicillin-resistant organisms sulfonamides occasionally have to be resorted to.

Sulfonamides find a definite place of use-

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fulness in the following acute pyogenic infections: erysipelas, widespread impetigo, cellulitis accompanying inflammatory dermatophytosis, furuncles, lymphangitis, early hidrosadenitis, and in some carbuncles. For all of these, penicillin serves an equally good purpose, but in many instances the use of sulfonamides is the more practical measure because of technical difficulties involved in the administration and expense of penicillin. Erythema nodosum responds well to sulfadiazine if there is a definite focus of infection. (The tendency of sulfathiazole to produce erythemanodosum-like lesions should not be overlooked.) Erythema scarlatiniforme responds only if there is a definite focus of infection, which must be eradicated to prevent future recurrences.

Certain chronic infections of the skin are benefitted occasionally but rarely cured only by sulfonamides. Of these, sycosis barbae is occasionally cured by short courses. The drugs are of distinct value in anthrax, actinomycosis, and chronic axillary abscesses in combination with penicillin therapy.

Sulfonamides are sometimes used in other skin conditions which are of unknown etiology: notably, pemphigus, lupus erythematosus, and dermatitis herpetiformis. They have been of doubtful benefit in any form of pemphigus, with the exception of those forms with attendant sepsis. They are of no value in the chronic discoid type of lupus erythematosus, and are reported to help only about 5 per cent of the acute disseminated types.[13]

UNTOWARD EFFECTS

The untoward effects of the sulfonamides may vary from mild rashes of the skin to toxemia. The eruptions may be morbilliform, scarlatiniform, purpuric, varioliform, urticarial, papular, vesicular bullous, or nodular. There may be a fixed eruption or exfoliative dermatitis. A photosensitization may be induced by the drugs, but does not usually remain chronic. Stomatitis may be caused. The reactions usually express themselves on the fifth to the ninth day, but may occur from the first to the thirtieth day of administration. The general toxic symptoms may be fever, acute hemolytic anemia, hepatitis, leukopenia, with granulocytopenia, acute agranulocytosis, hematuria, anuria, ocular and auditory disturbances, and rarely psychoses.

Increasing numbers of sulfonamide dermatitides following the local use of the drug in an ointment are being seen. Most of the cases follow sulfathiazole ointment, and the incubation period for the sensitization dermatitis varies from twenty-four hours to a week after initiating the ointment. Very few cases are seen following the use of the drug in either a paste or powder. The ointments commonly used are composed of a water-soluble base that softens the epidermis and *increases permeability of the skin. Practically all cases in which a sensitization dermatitis develops are ones in which the primary dermatitis was of an allergic nature, or exudative.* This fact corroborates the idea which is commonly held that the reactions in epidermal cells are intimately concerned with the beginning of an allergic state.

In the past few years the literature has contained increasing accounts of and warnings against setting up a sensitization state against the drugs by the indiscriminate use of them. Most of the accounts refer particularly to sulfathiazole, but the warnings are directed against all of the sulfonamides. Barber[1] has stated:

> "Sulfonamides are effective in certain skin diseases, but they should not be used indiscriminately for any condition. Both methods of application demand the most careful supervision owing to the risk of allergic hypersensitiveness of the skin and other tissues and of serious toxic effects on the liver, kidneys, and hematopoietic system. It is important to distinguish between allergy with normal excretion of the drug and toxemia with drug retention. In the former, desensitization can be achieved by further administration; in the latter, it is imperative to discontinue treatment. The risk of allergic hypersensitiveness and of toxemia is minimized by prescribing the drugs orally for short periods only, three to seven days, and by applying them locally for not more than five days. It is questionable, if, as has been claimed, use of sulfonamides locally in superficial infective dermatoses, such as impetigo contagiosa, possesses any advantages over rational treatment with older and safer remedies. In any event, long-continued topical therapy with sulfonamides should never be permitted. The skin diseases for which oral administration of sulfonamides has been used with complete and partial success are acute and chronic infections of the skin with various micro-organisms and certain toxic eruptions due to acute or chronic infections elsewhere than in the skin. In some diseases the efficacy of one member of the drug group may be greater than that of the others. Thus sulfathiazole is more effective than sulfanilamide in staphylococcic infection, and sulfapyridine appears to be the drug of choice in dermatitis herpetiformis, pemphigus vulgaris and pemphigus vegetans."

Ormsby[9] stated that sulfathiazole sensitivity may be experienced in 5 per cent and reactions to sulfanilamide are seen in 2 per cent of cases treated.

Shaffer, Lentz, and McGuire[12] reported 4 cases in which sensitivity was induced by local therapy and elicited by oral medication. Allergic studies were performed in 3: Passive transfer tests, performed with the Prausnitz-Kustner technic, were positive to sulfathiazole in all 3 and gave positive delayed tuberculin type reactions, as well as the early

wheal reaction. A direct patch test performed on 1 patient was negative despite the fact that the eruption appeared to be a contact type dermatitis. Two patients showed one plus reaction to Urbach-Koenigstein passive transfer test.

These authors wrote:

"Sulfathiazole used as a local cutaneous application can cause a local dermatitis with or without a generalized disseminate eruption. Instead of presenting the usual appearance of dermatitis venenata, the eruption often manifests itself as an exacerbation of the eruption for which the patient is being treated. In two of the patients the sulfathiazole seemed to produce a flare-up of the original process locally with an 'id'-like generalization. The eruption in another case was basically a vesicular and pustular dermatitis. With sulfathiazole sensitization the activity of the process increased and subsequently bullous lesions appeared. With increasing sensitization the process became pemphigoid. The eruption precipitated by the ingestion of sulfathiazole tends to begin and to be most severe at the sites where the drug was applied locally, although it may later disseminate widely. Here again it may mimic the eruption for which the patient is being treated. The primary dermatitis may set the reaction type or pattern for the sulfathiazole eruption or sulfathiazole sensitization may manifest itself as a Herxheimer-like exacerbation of the original eruption. Pronounced pyogenic sensitivity, especially to the staphylococcus, may be important as a predisposing factor in many of these eruptions."

Others have reported a sensitization dermatitis which follows local application of the drug.[2, 4, 5, 7, 8, 10, 12] Livingood and Pillsbury's experience[7] was that in 12 patients in whom a sensitivity to sulfathiazole was induced by local application of the drug to diseased skin, evidence of the sensitivity appeared when the drug was later administered by mouth.

The following case reports are illustrative of those patients commonly seen who suddenly develop a generalized dermatitis after using a sulfonamide cream.

CASE REPORTS

CASE 1.—A woman, aged 35, was afflicted with pruritis ani. Her doctor prescribed sulfathiazole cream. This was at first soothing. Within twenty-four hours the perianal dermatitis became aggravated, and there developed an erythema multiforme scattered over the body, particularly over the chest, face, eyelids, and forearms. The secondary lesions on the face, forearms, and sides of the neck and eyelids became edematous, and all were intensely pruritic.

CASE 2.—A janitress, aged 55, developed a dermatitis of the forearms which was probably due to chemical cleansers. This was of about six weeks duration. Then a troublesome dermatitis of the legs from weeds began. Several different medications were used to no avail. Edema appeared about the ankles, then some exudation. The patient continued working and not giving the skin the rest it deserved. After the dermatitis of the legs had been present about two weeks, her physician prescribed sulfathiazole cream. Within two days an extensive dermatitis appeared all over the body and extremities and face. There was also edema and exudative dermatitis over the face, almost closing the eyelids, and a dyshidrotic eruption of the palms and soles. The dermatitis eventuated into a mild exfoliative one after the edematous stage, and there was left on the lower parts of the legs a chronic dermatitis which has required treatment, rest, and protective dressings since (for ten weeks).

CASE 3.—A patient with a chronic otitis externa had been under treatment for weeks with dusting into the ear canal equal parts of sulfanilamide and sulfathiazole. The dermatitis and pruritis extended out upon the external part of the ear. Rubbing aggravated the inflammation. It became reddened. Sulfathiazole ointment was then applied. Very shortly thereafter she was referred to me for treatment of an acute exacerbation of the dermatitis which became exudative and edematous over the ear and side of the neck.

Once started, a dermatitis due to sulfonamide sensitivity is extremely pruritic and recalcitrant to treatment. The degree of the toxicity may vary from only a moderate amount of skin involvement to an exfoliative dermatitis with purpuric and pemphigoid characteristics, and disturbance of the hematopoietic system, with rarely death.

The dangers of the possible development of this sensitization through external applications of sulfonamides must be carefully considered, particularly since at some later time the need for internal administration of these drugs may be life-saving, and a high degree of hypersensitivity may prevent their adequate use in serious general infections.

It is questionable whether local application of sulfonamide ointments is superior to any old measures such as 5 per cent ammoniated mercury ointment, sulfur and acid salicylic, resorcinol, or oxyquinoline; and because of the potential danger from their use it is recommended that sulfonamide ointments be used most cautiously, and if used at all, for a period of not more than five days, and that they never be used upon exudative or allergic dermatoses. My opinion is that the use of any of the sulfonamides in ointment form is not necessary, except in rare instances as in the cases of patients sensitive to other antiseptics, such as mercury.

These ointments, particularly sulfathiazole and sulfadiazine, are prepared by the commercial houses in a pleasing soft water-soluble base which is soothing, and at first appealing to the patient, and thus can serve as a trap to unsuspecting patients and physicians. The products are popular among the laity because all of the good virtues of the drugs have been advertised, but none of their hazards. We can expect to see more cases of sensitivity because of the loose way in which sulfonamides are dispensed, ordered, and used.

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Medical Arts Building.

SULFONAMIDE THERAPY OF VINCENT'S ANGINA

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The treatment of Vincent's angina has been a protracted and rather unsatisfactory procedure in the past. This report deals with the efficacy of sulfonamides in the therapy of this disorder.

The disease under discussion is an acute tonsillar infection which results frequently in deep ulceration and is associated with the presence of large numbers of Borrelia vincenti and fusiform bacilli. The term "Vincent's angina" is used for convenience only, since the etiological role of the above-mentioned organisms is considered questionable by many.

In the past, treatment has consisted of the use of various antiseptic gargles, local application of such medications as iodine, chromic acid, potassium permanganate, gentian violet, merthiolate, and neoarsphenamine or mapharsen in glycerin, pastes of sodium perborate, and the parenteral use of the antisyphilitic arsenicals. That these modes of therapy have been somewhat less than satisfactory is attested to by their variety and number. The most widely favored, intravenous neoarsphenamine, is sometimes ineffective except after three or four injections. The use of this drug may even permit the development of the probably closely allied Vincent's stomatitis and gingivitis. This was observed by Ludwick[3] during the treatment of syphilis.

Priority in the use of sulfonamides for Vincent's angina belongs to Pelner,[5] who treated 1 case with azo-sulfanilamide, with a satisfactory result. Hirsch and Spingarn[1] treated 6 cases of ulcerative gingivitis and 2 cases of tonsillar infection with excellent responses. They continued treatment until the disappearance of the organisms from the lesions. One of their patients with tonsillar infection had infectious mononucleosis. Widespread attention was first drawn to the use of sulfonamides for Vincent's angina by the report of Linton,[2] who obtained prompt improvement in 4 patients. Recently Manson and Craig[4] reported on 48 cases. Their study demonstrated excellent results, all lesions having healed in ninety-six hours. The dosage employed was 12 to 18 Gm. of sulfathiazole in forty-eight to seventy-two hours. The medication was allowed to dissolve on the tongue.

Sixty-one cases of Vincent's angina from two Army Air Force hospitals were studied in making the present report. Of these, 41 were treated by the author and 20 by his associates. Soreness of the throat, usually unilateral, began

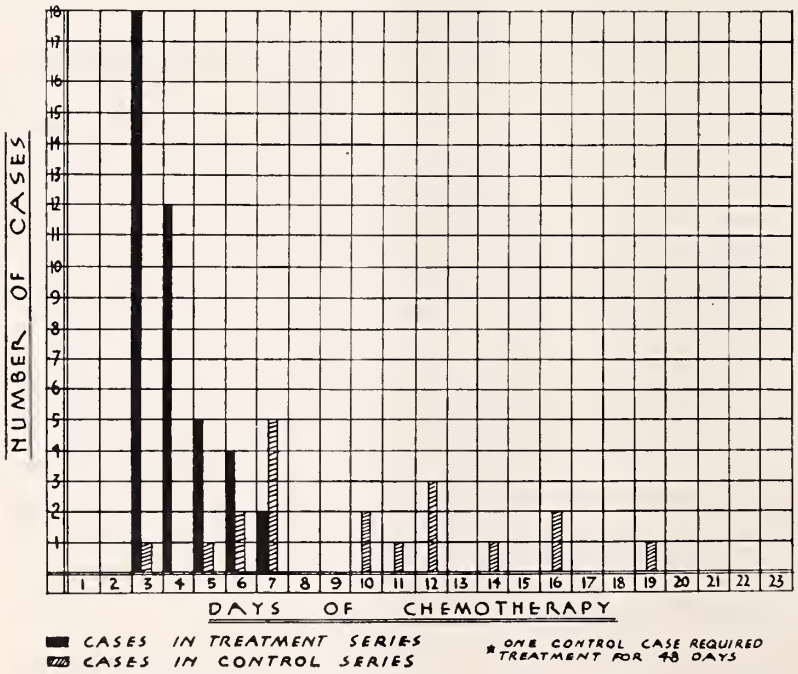

FIG. 1. Chart showing graphically number of days of chemotherapy required for the control of Vincent's angina with sulfonamide therapy, compared with number of days required with other methods of therapy.

gradually in most cases, and constitutional symptoms were slight or absent. The affected tonsils were gray and not particularly congested. The extreme enlargement and marked redness seen in acute follicular tonsillitis of streptococcal or other origin was not observed. Thirty-two of the patients had frank deep tonsillar excavations; the others had ulceration which was detected only when the exudate was wiped away. Darkfield examination was made in several cases; none was positive for Treponema pallidum. The tonsillar lymph node draining the affected side was usually considerably enlarged, firm, rubbery, and only slightly tender.

Exudate was always abundant, sheetlike, and malodorous, and was gray or yellow. Stained smears were made in 55 cases, and were positive in 53. All the cases with negative or no smears had deep ulcers, and the other clinical criteria were fulfilled. Presence or absence of Vincent's organisms in a smear was never allowed to be the chief criterion in diagnosis. Blood counts and blood smears were made in 53 cases. Only 2 showed any considerable degree of polymorphonuclear leukocytosis, both unquestionable cases with deep ulcers, and only 1 a lymphocytosis. The latter was not regarded as infectious mononucleosis of the usual type, as there was no titer for a heterophile antibody on several determinations.

It was considered that the cases included in this study could be readily differentiated from tonsillar infections of other types. Several, diagnosed as Vincent's angina by other staff members, were discarded because they did not fulfill the above clinical criteria.

All 41 patients in the treatment series received at least 6 Gm. of sulfadiazine or sulfathiazole a day, the standard dose for maintenance of therapeutically adequate blood levels. A few patients who received smaller daily doses were included in the control series. The total doses varied from 12 to 38 Gm., the most usual being 20 Gm.

The treatment given in the 20 control cases included chromic acid and gentian violet applications, neoarsphenamine or mapharsen in glycerin locally, neoarphenamine or mapharsen intravenously, and vitamin supplements. Most of the patients in both groups received peroxide and bichloride mouth washes. The results of treatment in the 5 cases in which inadequate doses of sulfonamide were given did not compare favorably with the adequately treated cases.

All patients were retained in the hospital until the ulcer had healed, or until all but extremely small amounts of exudate had disappeared. Thus it is possible to express the results in terms of days of chemotherapy and days lost from duty.

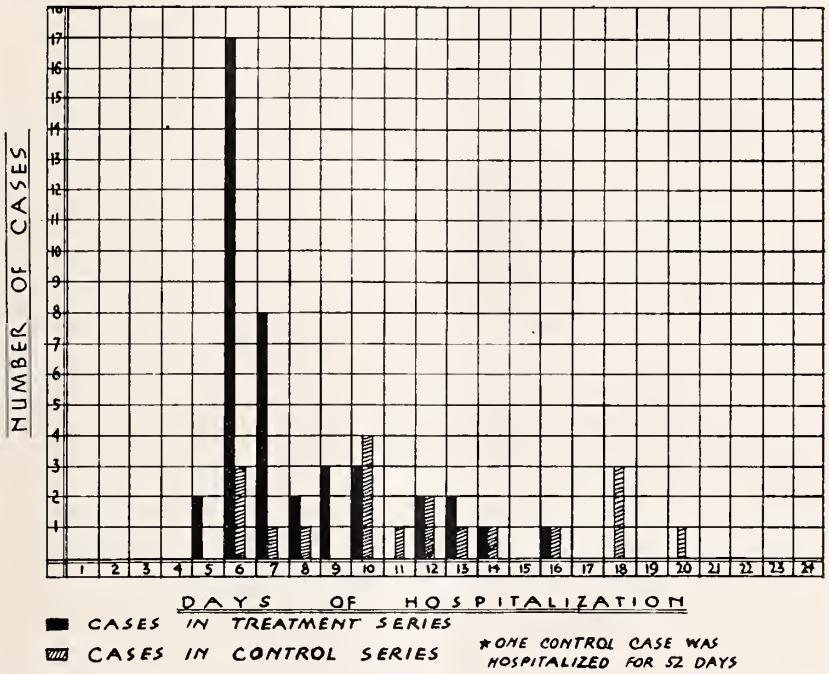

FIG. 2. Chart showing graphically period of hospitalization required for the control of Vincent's angina with sulfonamide therapy, compared with period of hospitalization required with other methods of therapy.

In 78 per cent of the adequately treated cases, the lesions were completely healed and the patients were ready for return to duty in less than ten days, while the corresponding figure for the control series was 25 per cent. Even more clearly demonstrating the greater value of sulfonamides are the following figures: 85 per cent of the treatment series received chemotherapy for five days or less, while only 10 per cent of the control series could be treated for five days or less. The results are analyzed in detail in figures 1 and 2. The superiority of adequate sulfonamide therapy was demonstrated also by the prompt diminution in soreness of the throat. Only rarely was there any discomfort after the first thirty-six hours of administration of the drug.

SUMMARY

1. Forty-one cases of Vincent's angina were treated with conventional doses of sulfonamides, and 20 received other modes of therapy.

2. Study of the results demonstrates the marked superiority of adequate sulfonamide therapy.

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OBSTETRICS IN THE POSTWAR YEARS

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Tonight it is my pleasant duty to welcome you to the sixteenth annual meeting of the Texas Association of Obstetricians and Gynecologists. Thanks to the wisdom of our Council during the past four years we have persisted in having our annual meetings. It was with some trepidation that we determined to have this meeting this year. However the trend of events has justified the wisdom of those who voted to have the annual meeting this year—come war or peace. The past few years have seen our ranks depleted by twenty-eight, which represents those of our number who are in the service. During these war years travel restrictions have made it very difficult to obtain speakers for our programs or to have good attendance of the members. We are happy indeed this year to have been so fortunate in concluding one of the most varied and excellent programs that we have had in the history of our organization, and I personally wish to offer thanks to every member who has contributed to this program and special gratitude to two of my friends who have come practically halfway across the continent to be with us today and tonight.

In casting about for a subject it occurred to me that we could do no better than to take stock of ourselves and to consider some of the problems that will be with us through the coming years. Consider for a moment the difference between the situation now and one year ago. Then it was a problem of holding the line, of keeping our diminished ranks intact and carrying on. That worry is now over, but we still have depleted ranks, no hopes of early replacements, and years of grinding labor ahead. Before taking up the case of the specialty of obstetrics let us consider the profession of medicine as a whole.

The A. M. A. Directory for 1942, compiled in late 1941, showed 180,496 physicians registered. The same year saw 1,245 physicians in the Army, 1,176 in the Navy—a total of 2,421 in the service. What were the figures at V J day? From these 180,000 physicians 60,000 had joined their comrades in the service. And how were these men chosen? To the everlasting credit of the A. M. A., these men were selected by local boards of Procurement and Assignment throughout the nation. By such country-wide selections the medical staffs of our Army and Navy were procured. The government looked to the A. M. A., and the A. M. A. delivered without employment of any draft. What a contrast to the nursing situation, a contrast caused by lack of vision and leadership in the nursing profession. When Von Runstedt's Battle of the Bulge was in full fury in December, 1944, the services awoke to the fact that there were far too few nurses. Then came frantic appeals, threats of a draft for nurses, and cold anger that any of our boys should suffer from lack of nursing service. The nurses could have been secured in the first place by the same system that furnished the doctors, but no one ever seemed to have thought of that.

The 120,000 physicians left at home we feel have held the line and have kept the faith. We take no credit for ourselves. Our patients have been forbearing and thoughtful of our extra burden; they have suffered inconvenience and delay with fortitude, for which we are grateful. There are no medals of honor for those on the home front. We expect none. To crown a man for doing his simple duty would be a crude gesture indeed.

With what armament have we fought these days? The heritage of medicine has been the accumulated experience of the race. Consider the record: of men wounded in battle, the lives of 95 per cent have been saved; the deaths from pneumonia (the Captain of the Men of Death) have been reduced 50 per cent; whooping cough (the chief killer under 5 years) has been prevented in 60 per cent of children; appendicitis shows a 98 per cent recovery record; cancer is controllable in 70 to 80 per cent of early cases—39,000 cancer recoveries officially recorded; diabetes has been brought under control; syphilis and gonorrhea are swiftly and surely treated. In our field, by intelligent prenatal care, greater comfort and fewer complications have occurred in pregnancy; easier labor has become a reality; the menopause a smooth unharried transition for 90 per cent of women. Such is the record; such the service rendered

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by our profession. Shall we not take pride in these achievements and agree with Sir William Osler when he said, "'Tis no idle challenge we physicians throw out to the world when we claim that our mission is one of the highest and noblest kind, not alone in curing disease but in educating the people in the laws of health, and in preventing the spread of plagues and pestilence"?

Our problems right now are both from within our ranks and from without.

1. The return of physicians to civilian status. This problem is not as easy as it sounds. Many of the men will desire new locations or refresher courses; a large percentage will be unable to resume their former strenuous labor—they will be casualties, both mental and physical. To date the loss of men who will never be able to return to full active civilian status cannot be accurately estimated.

2. America faces within the next five years the most appalling shortage of physicians it has ever faced. At the same time the population will have been increased by several millions. What are the causes for this shortage?

First is the usual average loss from death of 4,000 physicians annually.

Second is the reluctance or inability of the service to discharge physicians. The Army and Navy hospitals will be inadequately staffed if all physicians applying for discharge are granted release in the next two years. It is estimated the peace-time Navy will need 5,000 doctors, the Army 10,000. The Veterans Administration will require 15,000. This is 30,000 men. In six years, 1942-1948, 40,000 medical graduates will have been added to our ranks. In that time, at a death rate of 4,000 per year, 24,000 will have passed on, which leaves a residue of 16,000 to meet the need for 30,000 men, to say nothing of civilian needs. These are the figures of the committee, headed by Dr. Evarts A. Graham, of St. Louis, on postwar medical service, in a memorandum presented to Pres. Harry S. Truman in June, 1945. In the opinion of the committee failure to defer premedical students will mean writing off 5,000 physicians in the next three years, equivalent to depriving 100,000 hospitalized veterans, 1,000,000 soldiers or sailors, or 4,000,000 civilians of medical care.

This deficit has been aggravated by two short-sighted acts of the administration during the war. One was the failure, or rather the refusal, of the Selective Service System to defer students taking premedical studies. As a result there will be a period of four years or more in which only 4F's and women will be able to graduate as doctors of medicine. Even Britain during the blitz years, Britain whose citizens lost one-third of their homes and faced the imminent peril of invasion, persisted in keeping the premedical and medical students in the classrooms. The other act was a directive of the late Franklin D. Roosevelt, recently unearthed, which, late in 1944, compelled Army and Navy medical departments to assign a certain number of their officers to the Veterans Administration for use in their hospitals. This may keep thousands of physicians tied up in the service and chafing to get out to more active pursuits than keeping records. However, war controls are still on, and, unless Congress acts, no relief is in sight. The Ellender bill in Congress to defer premedical students received scant attention and no action. Indeed the medical profession has received little consideration of any sort from the administration. The application of the American Medical Association House of Delegates for a meeting in Chicago was summarily denied, but at the same time the 1,000 Club was smiled upon as its members trekked from the four corners to celebrate in Washington.

From these facts it appears that the civilian physician is faced with several more years of heavy duty before a new corps of medical graduates can bring help.

While the medical profession is thus faced with a definite thinning of the ranks of active physicians, it is also beset by another threat to its functions and efficiency; namely, the movement to institute some form of compulsory sickness insurance in the United States as expressed in the Murray-Wagner-Dingell bill. Such compulsory insurance leads to regimentation and totalitarianism. The late Samuel Gompers saw this threat back in 1916 when at a meeting of the A. F. of L. congress he declared, "Look over all the world where you will and see those governments where the features of compulsory benevolence have been established and you will find the initiative taken from the hearts of the people. Government power grows on that upon which it feeds. Give an emergency power and it at once tries to reach out for more. Its effectiveness depends on increasing power. For a mess of pottage under the pretense of compulsory social insurance, let us not voluntarily surrender the fundamental principles of freedom."

This, from a great labor champion of another day, in the face of the threat of present day compulsory sickness insurance championed by the C. I. O., makes us wonder whether the phrase in our constitution "to promote the general welfare" means to people fuller bellies, warmer clothes, better

shelter, rather than the more important values of freedom. I sometimes wonder if there are not too many people in our great land who would rather have security and bodily welfare than a guarantee of freedom. For the latter cause we have seen men suffer bodily privation and death at Valley Forge, at Iwo Jima and Okinawa, in the jungles and on the high seas. Did they suffer the pain in the flesh, the wounding, and the dying for freedom from want, disease, and hunger, or did they do it to preserve eternally the freedom of the spirit? To my mind it is high time that Americans take pause before changing basically what we so glibly talk of as the "American Way of Life."

Such is the sketchy over-all picture of medicine in the United States today. As a group whose specialty is that which supervises the most important single act of life; namely, the entrance into it, we are affected no little by all these problems and threats to our integrity as a profession.

First, we shall share with our fellow physicians the problem of scarcity of active men. I see no hope for relief from this situation under five years. To carry on the burden we have little but our own stamina and determination to aid us. Improvement in hospital facilities, better nursing service, which certainly is needed and not now out of reach, will help some, but the public will still have to be patient and forbearing for many years to come before our service can return to its former unhurried and unharried tempo. Grouping of obstetricians in clinics should be of some assistance, an arrangement whereby specialists may relieve one another at intervals will be of great help. Otherwise we shall have to hang on until a new generation of obstetricians is ready for service.

Second, such a situation threatens good obstetrical service because it gives little time or opportunity for study, mental exercise, and improvement of one's abilities. To my mind, outside of the physical wear and tear of the past few years, this has been the greatest loss we have suffered. As times are, it is too easy to keep in the same rut, use the same technic, and leave undone any investigation of newer and better methods and discoveries. Thus the war has made us almost perforce carry along with the status quo ante. Unless we petrify or fossilize, however, we must keep up with our studies, we must improve our technic, we must keep abreast of the new advances that come along. To do this we cannot hope for time for extended refresher courses, for postgraduate work, or extensive tours of medical centers. We will have to be content for awhile with our organizational meetings, county, state, and national, but above all with meetings of our special associations, such as this one, where in a short space of time we can learn new methods, discuss our problems, and refresh our spirits to carry on. In such meetings as these I see the means of carrying on our specialty as a living force until we shall have more time to study or take longer courses.

The solution of the present problem after all will be with the individual. The obstetrician like any other physician or like any other professional man faces a tremendous temptation at a certain period in his activities to rest upon his oars, to cash in on what he now knows or has already done, and to coast the rest of the way. If he falls prey to that temptation, he will not ride the crest of the wave, but will rust and rot. There is no more dangerous thing that can happen to a professional man than to stop looking forward.

This brings me to observe that while many of us have arrived at or have passed the meridian of life, we must not stop, we must not surrender the youthful outlook on life. Old age can be a lovely period, a crowning glory, or it can be a shrinking and a shrivelling of all that is best and noblest in man. Said Browning in Rabbi Ben Ezra:

> "Grow old along with me,
> The best is yet to be;
> The last of life for which the first was made."

However, someone has said, "It has been wisely pointed out that a man's age can be measured by the degree of pain he feels as he comes in contact with a new idea." Read the April 21, 1906, *Journal of the American Medical Association* and see how the profession looked upon the automobile with alarm and you will see the truth of this statement.

I hope in the light of that observation that none of us will ever grow old. Our usefulness to our fellow man depends upon how tenaciously we hold to the hope for newer and better things, both in our personal life and in our profession. And let me remind you that in keeping the forward-looking attitude, in looking for the newer and the better, we may stumble upon wonderful discoveries. In our daily practice and study who knows when we may grasp a new idea or a new discovery that may revolutionize our service and even the world? It is not too extravagant to expect this when we reflect upon some of the contributions that men have made to the race and under what circumstances they occurred.

Columbus, seeking the wealth of the Indies, discovered a New World; Coronado, looking for the seven fabled treasure cities of Cibolo

opened up a great Southwest; Stanley, searching for Livingston opened up the Dark Continent; in the scientific world Watt looked at the dancing of the kettle lid and the age of steam resulted; William Konrad Von Roentgen in 1895 studied the course of electricity through the vacuum tube, saw it cause a fluorescence on a nearby barium platinocyanide screen and gave us the roentgen ray; Becquerel puzzled over the fogging of a photographic plate resting in a drawer with some uranium and gave us the age of radio-activity and the split atom; Pasteur endeavoring to save France's wine industry from going sour discovered the existence of bacteria and almost discovered what Fleming actually did, when he attempted to find why a coworker's prize streptococcic cultures were not multiplying and found the answer in a mold, penicillin; Laennec watched children at play and invented the stethoscope; Auenbrugger observed vintners tapping their casks for fluid levels and evolved percussion; Domagk working to make Germany's dye industry supreme discovered the sulfa drugs; Semmelweiss noticed his maternity patients died when he went directly from an autopsy table to delivery room without washing his hands, thus starting the campaign to conquer puerperal fever; Christian Eijkman, in far off Sumatra, found his chickens sickened on polished rice and recovered on unpolished rice and gave us the vitamin era.

All of these men were going in one direction but found their jewel in a fortuitous bypath; but all were looking forward, were looking for something new. When they found it, accidentally, if you please, they were ready because, as Pasteur said, "In the field of investigation chance only favors the mind that is prepared." Nor are such discoveries, such pathways, beyond our ken. Sir James MacKenzie was a village doctor in Scotland and simply put down what he saw and what he thought. Yet no man has given to the world more knowledge about the human heart than he.

In closing, let me beseech you to retain the youthful outlook, to be ever on the alert for that which is newer and better. Have the vision of Ulysses as he assembled his men, already weary from wandering and searching and longing for home, and rallied them with these words:

> "Death closes all, but something ere the end,
> Some deed of nobler note, may yet be done.
> 'Tis not too late to seek a newer world;
> Push off, and sitting well in order, smite the
> sounding furrows.
> For my purpose holds to sail beyond the sunset
> And the baths of all the western stars
> Before I die."

1312 Main Street.

GASTRO-INTESTINAL LYMPHOSARCOMA

DIAGNOSTIC AND THERAPEUTIC PROBLEMS

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Hodgkin's disease, lymphosarcoma, and lymphatic leukemia are the varieties of lymphoblastoma encountered, but the majority of the gastro-intestinal lesions are of the lymphosarcoma type. Primary involvement of the abdominal nodes is much more common than generally realized. A great many such cases are overlooked or mistaken for other disturbances. The tendency to invade different groups of lymph nodes in different parts of the body or to infiltrate any structure in which lymphatic tissue is normally present or even structures in which lymphoid tissue does not normally occur, makes it possible for this condition to simulate almost any disease. "Although this condition may arise primarily in the gastro-intestinal tract, many of the cases of so-called primary lymphosarcoma of the gastro-intestinal tract actually start in the retroperitoneal nodes and extend into the gastro-intestinal tract, at which site they present their primary symptoms. Due to the fact that in many instances it is very difficult for the surgeon to explore the retroperitoneal nodes, this involvement is not always manifested."[11]

The pathological and radiological aspects of this condition have been previously discussed somewhat in detail by the author[18] along with presentation of 7 proved cases (patients with pathological diagnosis, subjected to operation). These aspects will be only mentioned and more attention will be given to the clinical and therapeutic aspects of the disease and why it presents a clinical diagnostic problem. There will be presented 4 cases of lymphosarcoma which manifested themselves as gastro-intestinal lesions in which no involvement of the peripheral lymph nodes or other manifestations of generalized lymphoblastoma could be demonstrated clinically. Each of these cases presented an interesting diagnostic problem.

PATHOLOGIC MANIFESTATIONS

In the gastro-intestinal tract lymphosarcoma originates in the submucosa, and invades in each direction, involving on the one hand the mucosa and on the other the muscularis of the bowel.

Grossly, the lymphosarcoma may produce an intrinsic, extrinsic, or infiltrating type of lesion. The manifestations vary clinically depending on the type present. Ulceration,

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though not infrequent, is often absent; but when it does occur, it is thought to be due to necrosis from pressure and loss of blood supply rather than from malignant invasion proper.

The microscopic picture presents a diffuse growth of lymphoid cells which lie in reticular tissue. Two types are recognized: the small cell lymphosarcoma or malignant lymphocytoma, and the large cells or reticulum cell lymphosarcoma. According to Ewing the structure of lymphosarcoma is rather specific, the nuclei are compact or vesicular, always hyperchromatic with nucleoli which are inconspicuous. Balfour and McCann pointed out that experienced pathologists occasionally hesitate to make a positive diagnosis in cases which prove by their clinical course and subsequent pathologic examination to be sarcoma. They referred to the case of Freeman in which a specimen was sent to several pathologists of note who diagnosed it variously as carcinoma, lymphosarcoma, inflammatory tissue, and chronic granuloma.

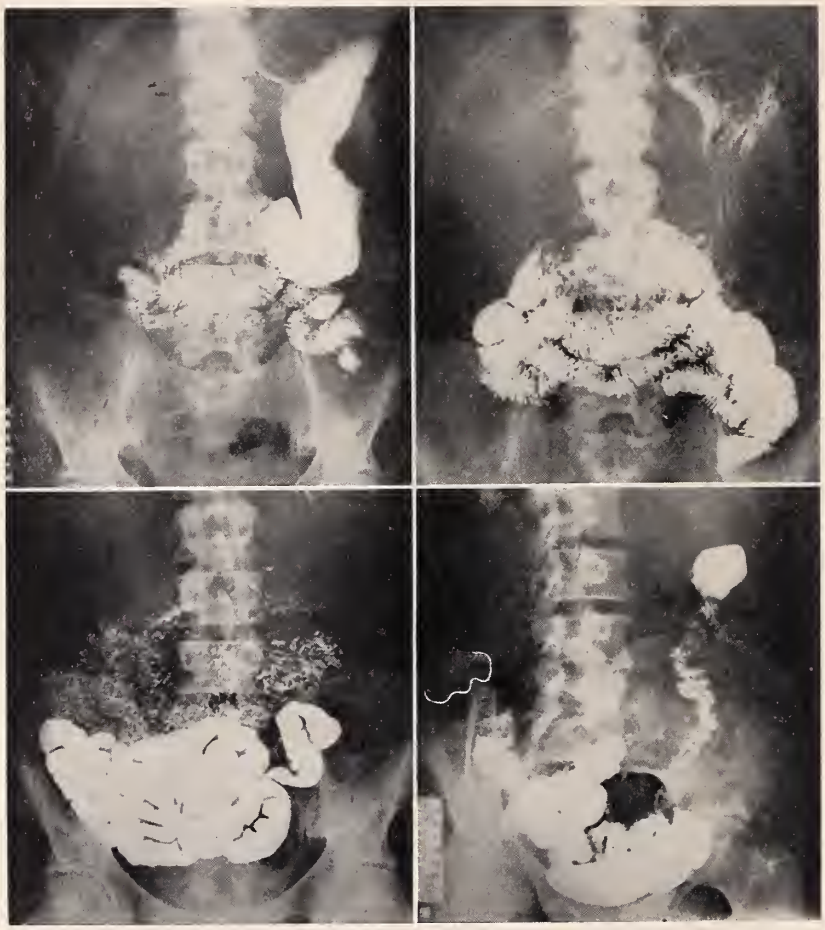

FIG. 1. Roentgenograms revealing a normal stomach and small bowel with head of barium meal in the cecum.

INCIDENCE

Primary lymphosarcoma of the gastrointestinal tract is relatively uncommon. Charache reported 404 cases of lymphosarcoma of the intestine in the literature. Several more have been recorded since his survey. Taylor reviewed 152 cases of lymphosarcoma primary in the stomach. O'Donoghue and Jacobs stated in 1942 that less than 500 cases had been reported in the literature and found the ratio of occurrence of lymphosarcoma of the stomach to cancer of the stomach to be 1:60 as compared to the ratio of 1:58 of the Mayo Clinic report.

In the intestines the most frequent sites of occurrence are the lower ileum, cecum, and rectum. Menne, Mason, and Johnston stated there are approximately 376 authentic instances of involvement of small intestines. The frequent occurrence about the cecum is thought to be due to the vast lymphatic supply in this area as compared to other parts of the intestinal tract. Usher and Dixon reported 36 per cent occurring in the cecum, 38 per cent in the jejunum and ileum, 20 per cent in the colon, and 6 per cent in the rectum.

Lymphosarcoma is found in all age groups. The greatest number of cases, as a rule, is encountered in the third and fourth decades, differing from carcinoma, which has its greatest incidence in the fifth and sixth decades. In cases previously reported[18] the youngest was 51 and the oldest 74 years of age. The average age was 61 years.

The incidence is greater in males than in females, that of lymphosarcoma of the intestine being about 2:1 as pointed out by Chont. Balfour and McCann reported the relative incidence of sarcoma of the stomach in males and females to be 25:1. In the author's series[18] there were 5 females and 2 males.

SYMPTOMS

There are no symptoms which are pathognomonic of lymphosarcoma of the gastro-

intestinal tract. In the early stages the symptoms are referable to the organ involved; later the systemic symptoms such as fever, loss of weight, and pruritus may occur and may be of aid in diagnosis.

In lymphosarcoma of the stomach, pain is the most common symptom; this may be a generalized abdominal pain, but more often is localized in the mid-epigastrium. It may be similar to that of peptic ulcer, but is not alleviated by the taking of food as a rule. The early occurrence of pain is apparently due to involvement of the submucosal plexus of nerves, as pointed out by Madding and Walters. Since the tumor originates in the submucosa, ulceration does not occur as early as in carcinoma. Other symptoms are belching, anorexia, epigastric nocturnal pain, and loss of weight and strength. Hematemesis is uncommon.

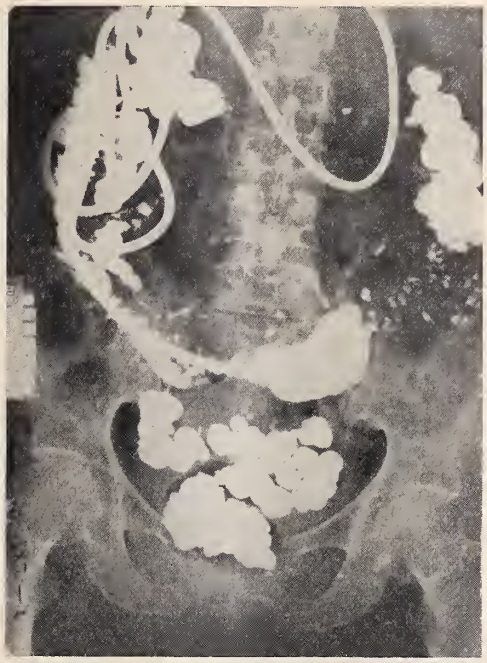

FIG. 2. Roentgenogram showing a Miller-Abbott tube in the small bowel with barium about the bulb revealing a complete obstruction of the ileum at this point. There is residual barium in the colon and terminal ileum from a previous examination.

In lymphosarcoma of the intestine, the classic triad is a palpable tumor, occult blood in the stools, and abdominal pain, although these are not found simultaneously as a rule. The condition may be diagnosed as appendicitis or some general constitutional disorder. The pain is colicky with little tendency to localize. The symptoms may also be those of acute or chronic intestinal obstruction, the former being found in the polypoid type of tumor due to intussusception and the latter in the infiltrating type as a result of invasion of the muscle layers of the bowel causing a paralysis and dilatation of the segment of intestine involved rather than a stenosis producing intermittent obstruction. Melena is infrequently encountered.

LABORATORY AND ROENTGENOLOGIC OBSERVATIONS

There is no characteristic blood picture for lymphosarcoma. When an anemia develops, it is usually of a microcytic, hypochromic type. Although Bunting, in 1911, described a specific blood picture for the diagnosis of Hodgkin's disease, this has not been confirmed. In a study on both lymphoblastoma of Hodgkin's type and lymphosarcoma, Roth and Watkins were unable to demonstrate a specific change in the blood picture. Decker, Leddy, and Desjardins found no characteristic blood picture in their review of 450 cases.

Gastric analysis is often of no value in diagnosis. Archer and Cooper reported 10 normal values out of 21 given. This is about the same as reported by Balfour and McCann, with free hydrochloric acid present in 60 per cent of cases in their series.

In lymphosarcoma of the intestine, occult blood is occasionally found in the stool.

Roentgenologic observations are not sufficiently characteristic to allow a specific diagnosis of lymphosarcoma of the gastro-intestinal tract in most instances. The majority of these lesions are diagnosed as carcinoma, possibly due to the great preponderance of this lesion. Even though in the gastro-intestinal tract a specific roentgenologic diagnosis is made in only few instances, this type examination is indispensable for (1) discovering the presence of the lesion, (2) determining, in most instances, its neoplastic nature, (3) sharply localizing the lesion, and (4) permanently recording the original involvement for the determination of its progression or regression at subsequent examinations.

DIAGNOSIS

From what has been said, it is plain that the clinical diagnosis of lymphosarcoma is somewhat indeterminate. A careful history and physical examination, particularly with the finding of peripheral glands or learning of such in the past, are of great aid. These, plus the finding of a gastro-intestinal lesion, might suggest the presence of lymphosarcoma. Holmes, Dresser, and Camp reported a case in which the diagnosis was made on such a basis.

A neoplastic lesion of the gastro-intestinal tract in a young person should bring to mind the possibility of lymphoblastoma.

Gastroscopic examinations may play an important part in diagnosing this lesion.

O'Donoghue and Jacobs cited a case by Gure diagnosed correctly by this method one month after a negative roentgenologic examination of the stomach. This can be explained by the rapidity of growth of many lesions as demonstrated by periodic roentgenologic examinations. Such an instance was reported previously in one of the author's cases;[18] however, the lesion was demonstrated radiographically the second time. Diagnosis of rectal lymphosarcoma by proctoscopic examination is difficult. Usher and Dixon pointed out that in all 10 of their cases of lymphosarcoma with rectal involvement visualized by proctoscopic examination, in no instance could the specific diagnosis be made on the appearance of the lesion. In 1 case of the author's series,[18] a specific diagnosis could not be made by proctoscopic examination.

It has been suggested that the therapeutic response to irradiation constitutes evidence of differential value. This is probably helpful in most cases, but apparently is not entirely dependable. Archer and Cooper cited a case diagnosed histologically by an excellent pathologist as lymphosarcoma and finally by Ewing as "round cell carcinoma having the same radiosensitivity as lymphosarcoma." Clinically this patient was well with no evidence of recurrence ten years later, having been treated with radiation therapy alone.

The preoperative diagnosis in practically all of these cases has been carcinoma. Madding and Walters pointed out that it would seem practical and highly desirable to perform an exploratory operation and obtain a specimen for biopsy even upon patients concerning whom the clinical evidence points strongly toward an inoperable growth. This seems to be well agreed on by other authors.

PROGNOSIS AND COMPLICATIONS

The prognosis for life is very grave. However, as a rule, it is better than that for carcinoma involving similar portions of the gastro-intestinal tract. Pund and Stilling stated that life expectancy after diagnosis averages two years. Charache found only 14 (13.6 per cent) of 103 carefully followed patients to have survived five years or longer. Taylor listed 11 patients out of 152 from the literature who had five-year survivals and added 2 cases. Archer and Cooper found 13 additional cases in a review of 94. They were forcibly struck by the fact that the longer the duration of symptoms before diagnosis, the greater the possibility of cure. Ten-year survivals are extremely rare.

Complications other than from spread of the disease are obstruction, perforation, and hemorrhage, the last mentioned being much less common than the others.

TREATMENT

The efforts in managing lymphosarcoma have been directed along the same lines as those used in treating carcinoma. Parker stated that the individual patient may have his life prolonged with proper management; but the ultimate mortality due to lymphosarcoma still remains unchanged. He stated that every patient who has responded favorably to treatment can be paralleled by a patient who has never had any treatment.

The apparently spontaneous remissions and the survivals among patients with lymphosarcoma, in spite of known inadequate therapy both from a surgical and irradiation standpoint, are puzzling features about the disease. Such cases have been reported by Taylor, Archer and Cooper, and others.

In localized lesions without metastasis, radical surgery of the involved segment and its mesentery, followed by roentgen therapy appears to offer the best results, according to Ritter and Shaffer, Carson, and others. If the condition is inoperable, side-tracking operations should be done as indicated and followed by roentgen therapy. Parker pointed out that it is well known that operations

FIG. 3. Photograph of specimen revealing a "napkin ring" obstruction of the ileum. There is dilatation of the bowel proximal to the lesion.

or infections are likely to start up an acute exacerbation in these patients, and that they are likely to die very soon following an extensive surgical operation. Where there is spread of the disease, even the most heroic surgery is valueless in most cases.

Irradiation should be employed in all cases either following surgery or as the sole means of treatment. In Desjardins' classification of tumors from the standpoint of radiosensitivity,[9] he found that the lymphoid cells were the most sensitive and that the lymphocyte occupied first position in this heading. Previously he had reported that the radiosensitivity of the lymphoid elements of lympho-

sarcoma was slightly greater than in Hodgkin's disease.[8] Taylor pointed out that the degree of radiosensitivity of the growth is not predictable from the study of the pathologic material.

Parker stressed the fact that a case with extensive involvement of a hollow organ is not favorable for heavy irradiation, particularly if a large amount is given in too short a time. Reeves emphasized that if a diagnosis of sarcoma of the stomach is made at laparotomy, irradiation alone is more satisfactory and treatment should be almost as heavy as for carcinoma. Holmes asserted that when lesions are localized in the gastrointestinal tract, complete removal either by irradiaton or surgery should cure the patient.

Jenkinson, Kinzer, and Brown found that the reticulum cell tumor was more resistant to irradiation than the lymphocytoma. This was also the opinion of Madding and Walters. Explanation lies in the fact that the former tumor originates from reticulum cells. In a series of 50 cases having intestinal involvement, including 25 cases of each type, reported by Usher and Dixon, there was no difference found in the radiosensitivity of the two. Portmann stated that no matter where the tumors originate, they have the same symptomatic and physical features, and malignant lymphocytomas also vary in their response to irradiation irrespective of their primary anatomic location.

Lymphosarcoma reacts more favorably to irradiation therapy than to any other form of treatment to date. There is still a wide divergence of opinion concerning the technic of irradiation for lymphosarcoma; however, space does not allow for descriptions or discussion of the controversial points in this paper. As emphasized by Parker, the two most important factors in irradiation therapy are the amount of radiation given at a time and the total period of administration. The wave length of the ray generated is not significant. However, Desjardins[10] and Leddy[7] emphasized the importance of low voltage therapy in the treatment of lymphosarcoma. For discussions of this subject, the reader is referred to the original articles.

CASES

Case 1.—A white woman, aged 51, registered at the Scott and White Clinic on March 28, 1941, complaining of a growth in the left side. Onset was five to six months previous with considerable indigestion, gas, and increasing constipation. Since a small girl she had had a mass in the region of the lower left ribs. This had been growing some lately. Because of loss of weight and weakness, she was referred to the clinic for complete examination and treatment. Physical examination revealed a lipoma 4 by 6 cm. in the lower left posterior axilla, a doughy thickening in the lower lateral quadrant of the left breast, but no definite mass; a tender, firm mass about 5 by 7 cm. in the upper left quadrant of the abdomen. Examination of blood showed 13.5 Gm. hemoglobin; erythrocytes, 4,760,000; leukocytes, 8,650, with 73 per cent lymphocytes. Roentgen examinations of the chest, urinary tract, pyelogram, stomach, and colon were normal. The mass was found to be outside these structures.

Left rectus exploration revealed a large friable tumor involving about 5 cm. of the lower jejunum. Adjacent mesentery contained large nodes. Enteroenterostomy was done to by-pass the growth.

The pathologic diagnosis was lymphosarcoma of the ileum.

The patient had a series of roentgen-ray treatments to the anterior and posterior abdomen, receiving 220 r per day to a total dose of 1,368 r per area not counting backscatter. Factors were 200 kilovolts, 18 milliamperes, 50 cm. distance, 1 mm. copper and 1 mm. aluminum filters.

She had two similar courses of roentgen therapy in July and October. The patient continued to grow worse and died on November 13, 1941, eight months after being first seen at the clinic.

Case 2.—A white man, aged 41, registered at the clinic July 14, 1944, having numerous complaints. The onset in September, 1943, began with cramps in the lower abdomen. He had had numerous examinations with conflicting opinions. In spite of many types of treatment, he had continued to grow worse. After one thorough examination he was told he did not have a cancer and to forget it. He continued to grow weaker and presented himself for examination and treatment.

Physical examination revealed an emaciated white male, weight 92 pounds; temperature, normal; respiration 18 and pulse 90. The examination was negative except for the abdomen. Visible peristalsis appeared in the left abdomen. Inspection showed the right renal area to be much flatter than the left. Rectal examination revealed a suggestive mass high on the left. This was quite tender, irregular, hard, and about 7 cm. in diameter. It felt like multiple nodules.

Proctoscopic examination revealed an extrinsic mass in the pelvis.

Examination of the blood revealed 12 Gm. or 80 per cent hemoglobin; 4,040,000 erythrocytes; 10,350 leukocytes; 74 per cent neutrophils; 17 per cent lymphocytes; 5 per cent monocytes; and 4 per cent eosinophils. A neutrophilia with some left shift was reported. The sedimentation rate was 55 mm. per hour.

Roentgen-ray examination of the small bowel revealed the lower ileum to be fixed in the pelvis. No obstruction was noted. A colon examination was negative except for the cecum being fixed low in the pelvis (Fig. 1).

Exploration was carried out on July 24 and revealed a lesion which was quite firm, involving 15 cm. of mid-ileum and 5 cm. of sigmoid. Another mass at the base of the bladder involved the sigmoid and cecum. The pathologist reported that tissue from the mass and node revealed a lymphocytic type of lymphosarcoma.

Postoperative roentgen therapy consisted of dividing the entire abdomen into four fields front and back with each area receiving a total dose of 728 r to the skin without backscatter. Factors used were 200 kilovolts, 1 mm. of copper, 1 mm. of aluminum filters, 50 cm. distance, 18 milliamperes, time necessary to administer 224 r which was given to one field daily.

The patient returned October 29 feeling much better. He had gained weight and was able to be up and about some of his business. Examination did not reveal any enlarged nodes or other significant finding. Examination of blood at this time revealed 11.5 Gm. or 76 per cent hemoglobin; 3,970,000 erythrocytes; 7,200 leukocytes; 69 per cent

neutrophils; 24 per cent lymphocytes; 2 per cent eosinophils; 3 per cent basophils; and 3 per cent monocytes.

Roentgen therapy was given again as noted above. He was given a transfusion and supportive treatment and at the time of dismissal blood examination showed 12.5 Gm. or 83 per cent hemoglobin; 4,120,000 erythrocytes; 5,600 leukocytes; 86 per cent neutrophils; 7 per cent leukocytes; 5 per cent eosinophils; and 2 per cent monocytes.

The patient returned home and seemed to get along quite well for a couple of months and returned to work. He later developed a marked anemia and leukopenia which did not respond to any type of therapy, including many transfusions, which were given by his local doctor. He continued to grow worse and died May 12, 1945, ten months after first being seen at the clinic.

CASE 3.—A 40-year-old white man entered the Santa Fe Hospital October 23, 1944, complaining of pain in the right lower quadrant of his abdomen, and that his "stomach" had been sore for a month. Two weeks previously he had vomited and was relieved. Pain and soreness remained in the mid-abdomen. Three days previously he again had a vomiting spell with generalized abdominal pain which remained until the day before he entered the hospital when it localized in the right lower quadrant.

Physical examination was negative except for tenderness over the entire abdomen with muscle splinting in the right lower quadrant. The peritoneal reflex was positive on the right.

Laboratory studies revealed that the white blood count was 7,350 with 64 per cent neutrophils and 36 per cent lymphocytes. The next day the count was essentially the same.

An appendectomy was done October 28 and the appendix was very difficult to expose because it was adherent behind the cecum. The pathological report was acute diffuse appendicitis. The patient had a very satisfactory postoperative course and was dismissed to return home November 11.

He returned sixteen days later with the same complaint. A clinician noted symptoms were those of a partial intestinal obstruction.

Physical examination this time revealed a palpable mass in the mid-abdominal area, which was firm and quite tender to pressure.

Studies of the gastro-intestinal tract were negative. Laboratory studies revealed 63 per cent hemoglobin; 3,260,000 erythrocytes; 12,500 leukocytes; 73 per cent neutrophils; and 27 per cent lymphocytes. The patient continued to get worse, and on December 30, a Miller-Abbott tube was placed in the small bowel.

Exploration on January 4 revealed loops of ileum adherent and an obstruction four feet from the cecum with a second obstruction one foot from the cecum. The entire mesentery was friable. The ileum was resected and a side to side anastomosis was done to the transverse colon.

The pathological report was lymphosarcoma, reticulum cell type, of the lower ileum. The patient had an uneventful postoperative course. From January 15 through January 26 he received roentgen therapy to four abdominal fields front and back, each receiving 768 r to the skin without backscatter. Factors used were 200 kilovolts, 1 mm. copper and 1 mm. aluminum filters, 50 cm. distance, 18 milliamperes. A daily dose of 224 r was administered.

The patient returned March 15 and received another and similar series of roentgen-ray treatments. At this time he was doing fine, but still had a very small palpable mass present.

He returned last for observation on June 18, 1945, having no complaint and no significant physical finding. A third series of roentgen-ray treatments similar to the others was given and the patient is to return for observation in three months.

CASE 4.—A 73-year-old white woman registered at the Scott and White Clinic on February 12, 1945, complaining of adhesions and hernias. About one year after an abdominal operation in 1932, she had developed hernia on the left side. She later began having cramping abdominal pain with much gas. Her condition had gradually become worse and she had had occasional spells of severe nausea and vomiting. At the time of entering the clinic she had severe cramping abdominal pain associated with nausea and occasional vomiting. Her bowels had been moving only with the aid of medicine and enemas.

Physical examination revealed the blood pressure to be 200/120; the heart had rough, blowing, systolic murmurs over all valvular areas, being maximal over the aortic and pulmonic regions; there was aortic sclerosis. The abdomen was slightly protuberant and tympanitic. No definite masses were felt, but some tenderness appeared along the right costal margin; there were bilateral reducible inguinal hernia and an old mid-line scar.

The physician attending noted that observations were classical of intestinal obstruction although there was little distention at the time.

Laboratory studies revealed 80 per cent or 12 Gm. hemoglobin; 4,420,000 erythrocytes; 6,200 leukocytes, with 68 per cent neutrophils and 23 per cent lymphocytes.

Roentgen-ray studies revealed Grade 2 enlargement of the heart and calcification of the aorta. A flat plate showed gas in the small bowel comparable with early obstruction of the ileum. A Miller-Abbott tube was passed, and barium injected into it revealed complete obstruction of the ileum (Fig. 2).

Exploration revealed a complete "napkin ring" type obstruction of the ileum about eight feet from the ileocecal valve. There was slight involvement of nodes in the mesentery. The growth was resected and a lateral anastomosis was done.

The pathologist reported Grade 4 lymphosarcoma of the ileum producing a stricture with complete obstruction and penetration of the bowel wall with involvement of adjacent lymph nodes (Fig. 3).

The patient had an uneventful recovery and was dismissed on March 11, 1945, to return in two months for roentgen therapy.

Follow-up revealed that the patient died at 2:30 a. m. April 28 in her home. The cause of death was a cerebral accident. The patient died thirty minutes after its occurrence.

CONCLUSIONS

1. Four cases of gastro-intestinal lymphosarcoma have been presented, the first having a palpable abdominal mass and tendency toward obstruction. The second presented a real diagnostic problem over a period of fifteen months with no definite physical finding and conflicting opinions. The third case simulated appendicitis, the patient returning only a few weeks after dismissal with symptoms of partial and later complete obstruction. In this instance, due to the small lumen of the appendix, it was probably obstructed early and presented symptoms just as noted with carcinoid tumors. The last case is interesting in that it presented a complete obstruction of the ileum by a "napkin ring" type of growth. This is the most unusual type of intestinal

lymphosarcoma as compared to the usual diffuse "cuff" type.

2. In no instance was there clinical evidence of the correct diagnosis.

3. Treatment consisted of surgery for biopsy and any further corrective measures that could be carried out. This was followed by roentgen therapy in all instances.

4. In spite of apparently adequate therapy, 3 of the 4 patients are dead, 2 directly from the malignancy, surviving eight and ten months respectively, and the third from a cerebral hemorrhage. One has survived eight months since first being seen and is apparently in good health.

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ALBERS-SCHONBERG DISEASE AFFECTING A SOLDIER

REPORT OF A CASE

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S. M. MOKROHISKY, MAJOR, M. C., A. U. S.
and
M. C. RITOTA, CAPT., A. U. S.

Albers-Schönberg first described the disease which bears his name in 1904 and published his original article in 1907. He used the term "marble bones" in his description because the roentgenographic density of the bones suggested marble to him. Since then such synonyms as "osteosclerosis," "osteopetrosis," and "osteosclerosis fragilis generalisata" have been employed to designate this rare and unusual condition. The term "osteosclerosis with anemia" was introduced by Ghormley, who reported a case in which definite anemia was present. The cause of the disease is unknown.

By 1923, 7 cases had been reported in the literature in Germany and 2 cases in the American literature. In 1926, Bernhardt stated that 16 cases had been reported up to that time. In the period from 1926 to 1928 reports of 10 additional cases were found by Pirie in the literature, to which he added reports of 4 cases. Uniquely, the 4 cases presented by Pirie occurred in one family; the patients were a mother and her three children. Pirie described the bones as chalky rather than as suggestive of marble. Zimmermann, in 1943, described what he stated to be the one hundred twentieth case reported in the literature. He wrote that the bones in this disease are subject to fracture with slight trauma. In the differential diagnosis of Albers-Schönberg disease the following conditions must be considered: fluorosis, Paget's disease, acromegaly, and erythroblastic anemia.

REPORT OF A CASE

An infantryman, 26 years of age, was admitted to the station hospital on January 28, 1945, complaining of difficulty in wearing a helmet of regulation size. He had served in the army for three years with a unit wherein he was not required to wear the helmet constantly. It was only when he was transferred to the infantry and was required to wear the helmet at all times that he had found it necessary to complain. Other than the difficulties referable to size of his head, he had had no symptoms. He had been seen in the neuropsychiatric clinic as an out-patient and a roentgenogram had disclosed that his head was unusually large. Moreover the bones of his head were found to be of unusual thickness and roentgenographic density. He was then admitted to the hospital.

His past history was normal save for the fact that his head always had been considered large. He had learned slowly as a child and his schooling had continued only through the fifth grade. He never had

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sustained what he considered to be a serious illness nor a severe injury and he never had fractured a bone. He was one of six children and no member of his family, as far as the patient could tell, suffered from a disorder similar to his.

The only outstanding physical finding was that of the unusually large head; it was not of abnormal shape. The circumference of the calvarium was 65 cm. The fronto-occipital diameter was 23 cm. and the bitemporal diameter, 18 cm. The size of the patient's skull can be appreciated when it is recalled that the circumference of the head of a man who wears a size 7½ hat, which is relatively large, measures about 59 cm. (Figs. 1 and 2). The man was 5 feet, 9 inches (175 cm.) tall and weighed 180 pounds (81.6 Kg.).

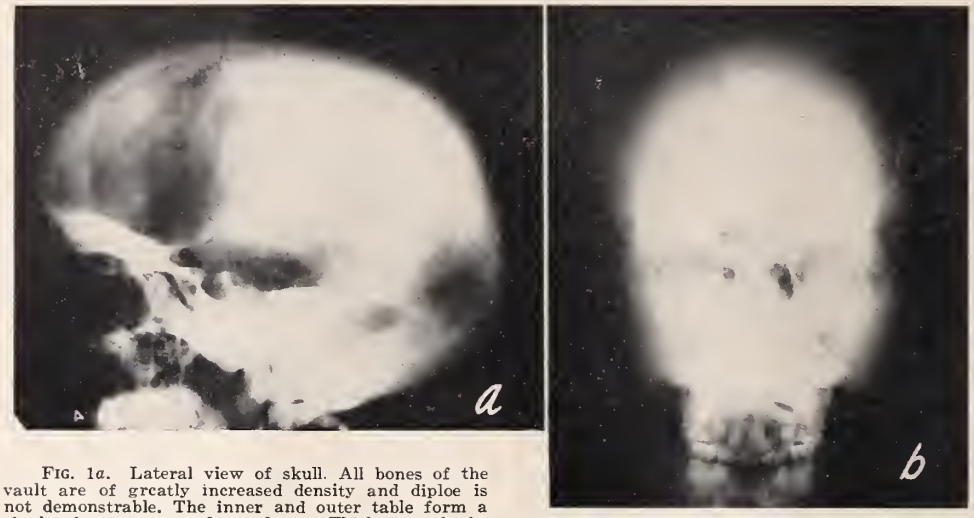

Fig. 1*a*. Lateral view of skull. All bones of the vault are of greatly increased density and diploe is not demonstrable. The inner and outer table form a single, homogeneous dense layer. Thickness of the cranial bones ranges from 1.6 cm. in the frontal region to 3.3 cm. in the occipital region. The sella turcica is normal in size and bridging of the clinoid processes is incomplete. Vascular channels of the internal table are apparent only on overexposed roentgenograms and are narrower than normal. The suture lines are obliterated. The mastoid processes are apneumatic and the frontal sinuses are small.

b. Bones of the face. Density is homogeneously increased and trabecular structure is obliterated, except that in the mandibles, trabeculation is still discernible. The maxillary and ethmoid sinuses are of normal size. The teeth are of normal density and the pulp cavities are radiolucent.

Ophthalmologic examination revealed that vision of each eye was 20/20 without correction. The margin of the left optic disk was poorly defined and the disk was grayish; the normal physiologic cupping was absent and the findings were interpreted as indicative of early papilledema. Examination of the ears, nose, and throat gave normal results. Hearing was normal. The patient had all of his original teeth and they were in perfect condition.

Thorough laboratory studies of the blood and urine gave normal results.

COMMENT AND SUMMARY

Albers-Schönberg disease is characterized most frequently by diffuse increased roentgenographic density of all of the bones of the body, a tendency of the bones to fracture easily, faulty dentition, optic atrophy, deafness, and anemia.

As the history indicated that this soldier's skull always had been enlarged, probably he had had Albers-Schönberg disease all of his life. Nevertheless, although his bones were of characteristically increased density, he never had had a fractured bone; yet he had engaged in rather strenuous activity. The dental equipment of the patient was perfect. This not only is an unusual feature to encounter in association with Albers-Schönberg disease but also it bears on a statement made early in this paper; namely, that fluorosis must be considered in the differential diagnosis of Albers-Schönberg disease. The perfect dental equipment of the patient furnished a relevant differential point. In fluorosis, the enamel of the teeth is mottled. Although the patient had no visual symptoms, ophthalmologic examination revealed evidence of mild, early papilledema in his left eye. His hearing was not impaired. The patient's bones were very dense (Fig. 3) and it might be expected that some encroachment

Fig. 2. The optic foramina are normal and equal in size, measuring 6 mm. in diameter. (The normal average diameter is 4.3 mm.)

on the bone marrow would be found; nevertheless, studies of his blood gave normal results. Moreover, in this patient's case there did not appear to be a hereditary or familial element.

The features which make this case worthy of report are that had the patient's head not been of unusual size the diagnosis would not have been made at all and, even as events turned out, diagnosis was not made until the twenty-sixth year of his life.

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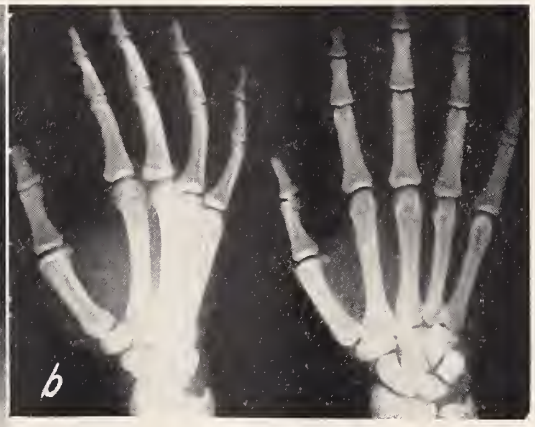

FIG. 3*a*. Lumbosacral portion of the spinal column and bones of the pelvis. The density is greatly increased. Trabeculation of the laminae, pedicles, and articular processes is obliterated. Only faint trabeculation of the vertebral bodies and of the transverse and spinous processes can be visualized. Increased density of the bones of the pelvis is generalized but a cancellous structure is still apparent. The lumbar paraspinal ligaments are calcified and this calcification is most evident on a level with the second and third lumbar bodies.

b. All bones of the hands have acquired generalized increased density but the medullary cavities are still apparent.

ACTION OF PENICILLIN PROLONGED BY CHILLING OF INJECTION AREA

Gonorrhea patients have been effectively treated with one large dose of penicillin injected into the upper arm muscle after thorough chilling of the area with ice, according to a report appearing in the March 9 issue of *The Journal of the American Medical Association*. This chilling is done before and after the injection to prolong the effects of the drug.

Lieut. Commander Max Trumper, from the Naval Medical Research Institute, and Commander Gershom J. Thompson, from the U. S. Naval Hospital, say that they treated 100 patients who had uncomplicated gonorrhea. These patients were divided into three groups, group one receiving 50,000 units of penicillin dissolved in a salty solution, group two receiving 70,000 units, and group three 100,000 units.

The resultant cures in the first two groups were 77.3 per cent and 85.7 per cent respectively. The 100,000 unit dosage cured 91 per cent of the patients. Commenting on this, the authors say that "this percentage compares favorably with the results obtained by others using multiple injections as well as the single injection of 100,000 units of penicillin in mixtures of beeswax and peanut oil.

"It can be concluded from the high percentage of cures that the chilling technic prolonged the effective action of penicillin, reduced to one the number of injections required to treat uncomplicated gonorrhea and rendered that injection painless, all of which was accomplished without introducing any other foreign substance intramuscularly."

The experiments were carried on at the National Naval Medical Center at Bethesda, Md.

INFANTILE PARALYSIS IN SUMMER CAMPS

A summer camp where poliomyelitis, more commonly known as infantile paralysis, has occurred need not be shunned, according to the April 13, 1946, issue of *The Journal of the American Medical Association* in answer to a query. The disease is not spread by a locality but rather is transmitted from person to person both directly and through carriers.

The fear was expressed by a New York doctor of sending children back next summer to a Pennsylvania camp where 11 cases of poliomyelitis were reported within two weeks. *The Journal* answer follows in full:

"The means of spread of the virus of infantile paralysis has not been worked out completely. It is, however, recognized that the disease is not one due to a 'place infection' but is transmitted from person to person probably both directly and through vectors. Therefore there would appear to be no reason for not recommending a summer camp, dwelling, or community because cases were reported there during the previous year."

TAYLOR COMBINATION OXYGEN TENTS

FOR ADMINISTRATION OF OXYGEN TO INFANTS, CHILDREN, AND ADULTS

T. A. TAYLOR, M. D.
LUFKIN, TEXAS

For the administration of oxygen at the Taylor Clinic we have designed a small oxygen tent unit for infants and children, and a larger unit for adults. The accompanying pictures show these units in use (Fig. 1*a*, *b*, *c*).

All patients, whether infants, children, or adults, are placed in the tent, rather than under the tent. This makes it possible to maintain a high concentration of oxygen when needed.

From the Taylor Clinic.

An ice chamber (Fig. 1*d*) is enclosed in the tent and designed to be placed at the head of the bed when in operation. The ice chamber is supported by metal rods extending from the ice chamber and resting on the mattress. This arrangement makes it possible to raise and lower the bed to any angle desired. The ice chamber is designed with openings at the top and bottom of the chamber which cause a convection circulation of cool air in the tent. There is an adjustable shutter in the upper and lower openings of the chamber to regulate the desired temperature in the tent. A sponge in the bottom of the ice chamber is kept wet by the melting ice to prevent the humidity from becoming too low when administering a high concentration of oxygen. It is not necessary to use soda lime to absorb carbon dioxide thrown

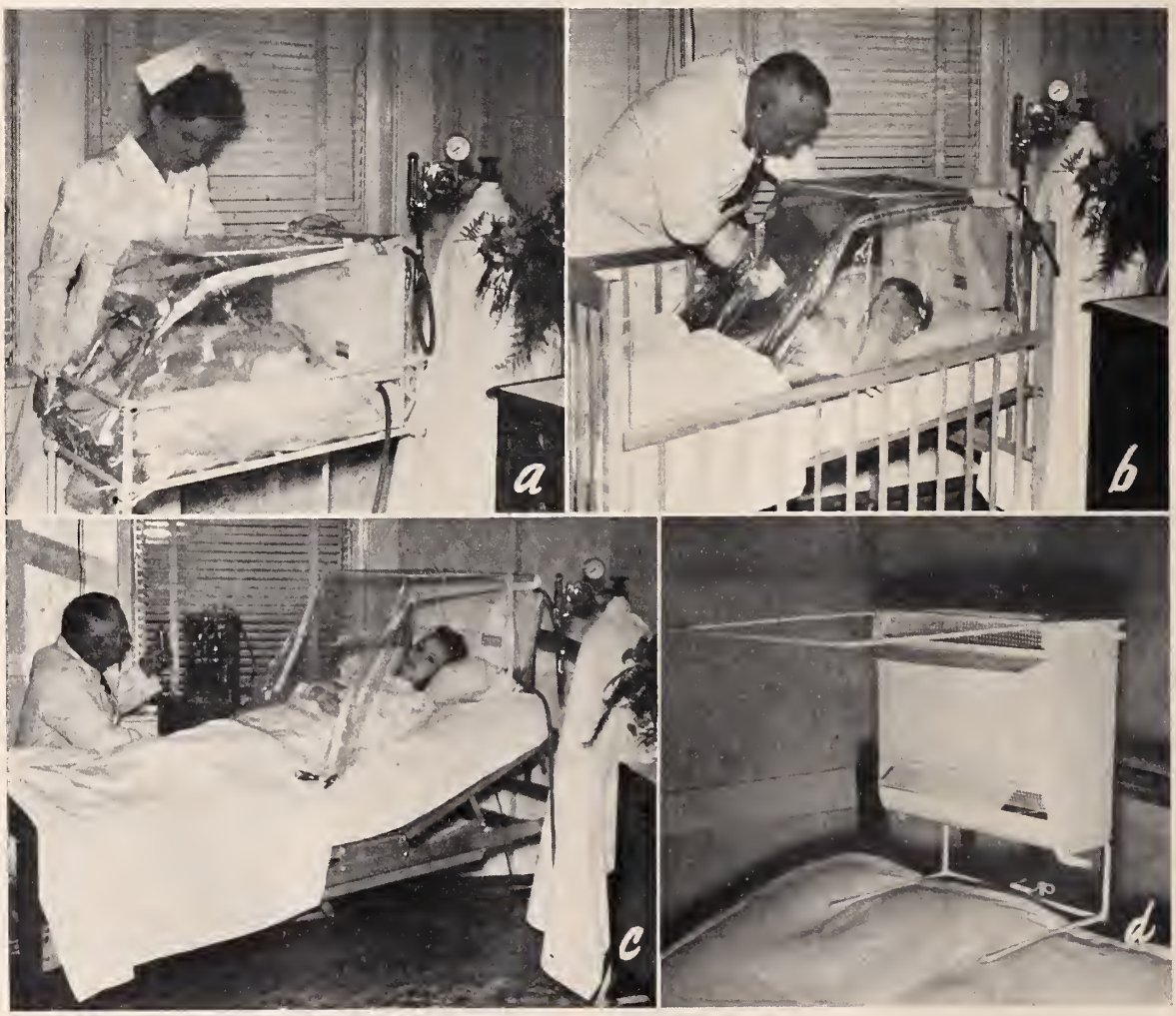

FIG. 1*a*. Oxygen tent unit in operation in a bassinet, adapted for the treatment of infants.

b. Treatment of a small child in a baby bed with the same ice unit as in *a* but with a larger tent. All tents have a zipper just above the ice chamber for putting ice into the chamber.

c. A larger ice unit and tent for the treatment of adults, and the means of testing the oxygen meter for graduating the proper concentration of oxygen. Further use of gas analysis will not be necessary as the concentration of oxygen can be regulated with the oxygen meter.

d. Ice chamber in the proper position at the head of the bed with the tent removed. Note the cord just above the mattress that connects the unit to the bed. This cord should be tied loosely around the railing of the bed to hold the tent and ice chamber in proper position when raising and lowering the bed.

off by the patient because the volume of air and oxygen given reduces the carbon dioxide in the tent to a point that it is not injurious to the patient. For infants needing a warmer air, hot water bottles may be placed in the chamber.

The desired concentration of oxygen may be accurately administered without the use of gas analysis. We have designed an oxygen meter or oxygenaire mixing valve which is connected to the oxygen gauge. It is graduated so that a specific amount of air can be administered with the oxygen, and by setting this valve with a certain liter flow of oxygen it is possible to administer and maintain any desired concentration of oxygen in the tent, from 40 to 90 per cent. The ability to administer a high concentration of oxygen when desired is one of the advantages of these tents, for at least two-thirds of all patients treated with oxygen need a high concentration at some time during their treatment.

For infants and children the small tent that fits into the bassinet and child's bed is very convenient and satisfactory in every way. It offers an advantage over previous methods that we have used. Oxygen tents in which a high concentration of oxygen can be administered when needed have proved to be the most satisfactory method in our hands. Both units described and illustrated here are very portable and weigh about fifteen pounds. They can be manufactured at a very low cost and can be used for all classes of patients from infants to old age. All-over transparent tents are much more pleasant for the patient than tents ordinarily used.

While we have used many different methods for administering oxygen in our clinic, for good oxygen therapy we like the small tents described above better than any method previously used.

CANCER OF LUNG INCREASING

Cancer of the lung, which accounts for at least 5 per cent of all cancers, is apparently on the increase, according to Abraham Oppenheim, M. D., of Harlem Hospital, New York. As in other types of cancer, cure is possible with early diagnosis and treatment.

Writing in *Hygeia*, Dr. Oppenheim says that cancer of the lung may occur at any age although it predominates in persons between the ages of 40 and 60. Men are most often stricken, totaling 83 per cent of all cases.

TUBERCULOSIS OF LARYNX

A New York physician, Dr. Mervin C. Myerson, reports that sulfanilamide spray has proved useful in alleviating the agonizing pain frequently associated with tuberculosis of the larynx.—J. A. M. A., April 13, 1946.

SYMPOSIUM ON CANCER RESEARCH

A symposium on cancer research was held April 13, 1946, at the University of Texas M. D. Anderson Hospital for Cancer Research in Houston. Seven invited speakers from Austin, Galveston, and Houston presented papers.

Dr. E. W. Bertner, acting director of the hospital and president of the Texas Medical Center, gave the "Welcoming Address." He pointed out that two symposia a year are planned to discuss various phases of cancer research. Basic research and clinical programs will alternate and panels of outstanding speakers will be invited. The development and future of cancer research in Texas were briefly stressed.

The following abstracts of the scientific presentations were kindly submitted by the speakers.

Dr. C. D. Leake, vice-president of the Medical Branch of the University of Texas, spoke on "Developing Lines of Cancer Research":

It is peculiarly fitting that we should, during National Cancer Week, take stock of our research opportunities in cancer. The current interest in cancer has been occasioned by our success in public health. Preventive medicine measures and effective public health have greatly increased the expectancy of life, with a resulting great increase in the incidence of cancer. Effective control of cancer is dependent upon a thorough understanding of its cause. The greatest opportunity in cancer research is that of coöperation. All kinds of scientific workers, together with medical men and health workers in all fields, can effectively coöperate together in cancer research. The M. D. Anderson Hospital for Cancer Research is established by the people of Texas to be a center for cancer research throughout the state. Generous coöperation among scientific workers all over the state, together with physicians throughout the area, can afford the best stimulus to the M. D. Anderson Hospital for Cancer Research to exert its guiding influence in fundamental as well as clinical research on malignancy.

Dr. Stuart A. Wallace, Fulbright professor of pathology, Baylor University College of Medicine, Houston, discussed "Some Problems Associated with Tumor Development and Behavior in Man":

One of the problems which arises is whether or not masses are true neoplasms. Benign tumors frequently have a known etiology and there is a tendency to consider them not true neoplasms, for example, nasal polyps, thought due to allergy, and keloids, thought due to a marked overgrowth of repair, mainly in the Negro race. In many respects, however, they behave as tumors.

In regard to development of malignant tumors, there is a variety of causes or predisposing factors. Cohnheim's cell rest theory accounts for such tumors as mixed tumors of mediastinum and others arising from misplaced cells during fetal development.

Heredity has been accurately proven in white mice, but the results cannot be applied to man with any degree of certainty. There were 159,926 deaths due to cancer in the United States in 1941. When such a large number die of malignant tumor, it is possible to have so-called cancer families without heredity playing any role.

Virus causes tumors in animals. In man, proof is required, although some investigators hope to find a virus as the cause of cancer.

Physical agents play a definite role in the causation of cancer. Marked prolonged exposure to sunlight or roentgen rays incite the development of cancer of the skin. Roentgenologists develop leukemia more frequently than others and workers with radioactive substances have developed bone sarcoma.

A few tumors are ascribed to previous repair processes such as bone sarcoma at the site of an ancient fracture, and liver carcinoma in cirrhotic liver. Hormones have a definite effect on rate of tumor growth and possibly on their development. Chemical carcinogenic agents are known to produce cancer in animals and also in man.

Thus there are many factors of which a few were discussed in the causation of cancer. We do not know the ultimate cause of cancer. Many of the above factors may act as preparing the cells for abnormal growth or in preparing the cells for action by another agent.

Much experimental work has been done in animals, some of which can be applied to human beings, but, unfortunately, much does not apply.

The difficulties of deciding microscopically borderline lesions were discussed. Since there is no stain or chemical analysis capable of detecting precisely malignant cells, the early and questionable lesions constitute a daily recurring problem to the pathologist.

Dr. C. M. Pomerat, professor of anatomy, the University of Texas Medical Branch, spoke on "Some Approaches to the Cancer Problem by Means of Tissue Culture Methods":

By 1911 it had been proved that both carcinomatous and sarcomatous cells could be maintained *in vitro* but it was not until some fifteen years later that the continuous culture of malignant cells in pure strains was fully established. Such elements have been demonstrated capable of producing characteristic neoplastic growths after having been removed from the host animal for several years. Experimental malignancies produced by chemicals can be cultivated and induced *in vitro*. Tissue culture technique has established that malignancy is a permanent characteristic located in the cells themselves. They grow vigorously but little difference can be found between them and nonmalignant cells with respect to colony formation, residual growth energy, rate of proliferation, and survival under adverse conditions.

Tissue culture methods offer an excellent means of establishing the diagnosis of brain tumors since characteristic cells can be found in nerve tumor outgrowths. Recent investigations by Willmer and his associates have demonstrated that cells *in vitro* probably owe their growth energy to a nonphosphorylating glucolytic system. Embryonic juice apparently brings about a decrease in carbohydrate metabolism and an increase in protein synthesis. These events have not yet been found to differ significantly in the activity of malignant versus nonmalignant cells *in vitro*.

Dr. Alfred Taylor, the Biochemical Institute, the University of Texas, Austin, discussed "The Present Status of the Virus Concept in Cancer Research":

The cell autonomy hypothesis of cancer causation has dominated cancer research for many years. This concept considers cancer induction and development to be due to an irreversible change within the affected cells. It is maintained that the cell is the common denominator for all the multitude of influences which induce malignancy in normal tissue. Once the transformation from normal cell to malignant cell has occurred, no continuing cause is necessary.

The other main concept considers cancer to be the result of the establishment within the cell of a specific tumor agent (a virus). As the tumor develops, there is a concomitant reproduction of cells and tumor agent. The specific tumor agent or virus concept is supported by laboratory observations beginning with the demonstration of virus causation for the Rous sarcoma in fowls.

Several papers have been published from the Biochemical Institute of the University of Texas giving the results of investigations designed to demonstrate tumor production in mice with cell-free extracts of materials from eggs containing implants of mouse mammary carcinoma. Successful experiments with both Berkefeld filtered extracts and lyophilized yolk from eggs containing yolk sac implanted mouse mammary tumor have been reported.

In association with these studies, mouse mammary carcinoma has been cultivated in eggs continuously for nearly three years. Recently it was noted that when tumor tissue from the egg series of mouse tumor was injected back into mice, the tumor which resulted was frequently a mixed carcinoma-sarcoma. Since the egg grown tumor has always remained histologically stable, transplants can be made into mice with the same basic material and the induction of malignancy in the normal cells of the stroma studied for long periods of time under various conditions. In this manner various types of highly malignant neoplasms have been obtained.

Using these different methods of approach, mammary carcinoma, lymphosarcoma, spindle-cell sarcoma, round-cell sarcoma, and many tumors not classified have been produced in mice by a tumor agent or virus obtained from mouse mammary carcinoma. In view of these data it would seem that the virus or specific tumor agent concept of cancer causation can be extended to mouse tumors in general. Further, since extensive research has shown the biological and biochemical similarity of mouse and human tumors, the primary cause of the cancer disease in man may also prove to be in the same category.

Dr. W. A. Selle, professor of physiology, the University of Texas Medical Branch, spoke about "Extrinsic Factors in Carcinogenesis":

One of the most fundamental discoveries in the field of cancer research is the observation that certain chemical and physical agents when in contact with animal tissue are capable of inducing cancer. More than 280 chemical carcinogens, widely differing in structure, have now been found. Curiously enough, among the substances of closest chemical similarity, one compound may be highly carcinogenic, another entirely inactive. There is, then, no correlation between molecular structure and carcinogenic potency. Another equally significant discovery is the observation that extrinsic factors of various types alter the activity of these carcinogenic agents. The species, genetic constitution, age, and sex of the animal employed, the site of application, the amount and composition of the diet, trauma, and certain physical factors of the external environment, such as temperature and ultraviolet irradiation, all tend to influence carcinogenesis. Since the causal and formal genesis of cancer is not understood, the agency by which extrinsic factors operate to accelerate or retard carcinogenesis is entirely unknown.

Trauma is one extrinsic factor about which there has been much controversy. It is still doubtful whether a single trauma can produce cancer in a

normal tissue. Trauma to tissues in a preneoplastic condition, however, seems capable of stimulating tumor formation. Increased environmental temperature reduces the incidence and time of induction of spontaneous mammary tumors of the mouse, but enhances tumor formation in an animal exposed to ultraviolet light, or painted or injected subcutaneously with a chemical carcinogen, or injected with tumor cells from another animal.

Converging evidence from various sources indicates that diet and the nutritive state play a most significant role in the induction of tumors, but a relatively minor one in the further progress of already established tumors. In general, tumors tend to develop earlier and in larger numbers in animals maintained in a good nutritive condition. Restriction in caloric intake diminishes the incidence and increases the induction period of spontaneous mammary tumors and tumors induced by the painting or injection of chemical carcinogens or by exposure to ultraviolet light. Likewise, diets deficient in necessary constituents, such as the amino acids, lysine and cysteine, suppress carcinogenesis. The inclusion in the diet of certain fats tends to augment tumor formation. On the other hand, workers at the University of Wisconsin have reported that inclusion of small amounts of coconut oil or lauric acid inhibits the formation of liver tumors by butter yellow. While some writers advocate for cancer prevention in man the eating of a minimum of carefully selected food, there is no direct evidence as yet that rigid dietary measures are of value in the control of human cancer. It has been argued that effective anti-cancer diets must be so drastic as to be impracticable. It has also been pointed out that nutritionally poor diets tend to favor the development of liver cancer in rats and mice. Generalizations regarding diet and cancer in man are thus hazardous at this time.

Continued studies of the accelerating and retarding influences of extrinsic factors on carcinogenesis will help toward a better understanding of the transformation occurring within the cell which results in the riotous and uncontrollable proliferation. Such studies may lead to the discovery of potent inhibitory factors feasible of application in the human being.

We look forward to the day when such naturally occurring influences are known and means are devised whereby cancer may be adequately prevented. To hasten that day, it would seem that we need to apply to the cancer problems the energy, determination, and coöperative effort which proved effective in solving the military and medical problems of total war. Organized cancer research on a large scale is long over-due.

Dr. A. N. Taylor, associate professor of physiology, the University of Texas Medical Branch, gave a paper on "Nucleic Acid Metabolism":

The work of Miescher in which he isolated chemical substances from the nucleus and called them "nucleosins" was one of the first contributions to our understanding of the metabolism of what we now call nucleic acids. Our present knowledge of nucleic acids, their structure, chemistry, and distribution, is based largely on the investigations of Levene and his coworkers.

A nucleic acid in its simplest form is an ester of phosphoric acid and an organic radical; the organic radical consists of a sugar and a nitrogenous component which is a cyclic derivative of urea. The nucleic acids were recognized early as being of two types differing in the carbohydrate and in one of the pyrimidine bases. It was thought that ribonucleic acid (yeast nucleic acid) was confined to plant cells and desoxyribonucleic acid (thymonucleic acid) to animal cells. It is now recognized that both types exist in all cells, thymonucleic acid being found on the protein framework of chromosomes and ribonucleic acid being found in the nucleolus and in cytoplasm.

Employment of newer techniques such as the Feulgen nucleal reaction, ultraviolet spectroscopy, enzymatic hydrolysis, and the ultracentrifuge has added greatly to our knowledge of the relationship of the two nucleic acid types to one another, and of the extent to which these acids enter into the vital cellular activities. It has been shown that there is an increase in the concentration of ribonucleic acid in the cytoplasm of maturing eggs, and that there is a decrease of the ribonucleic acid which parallels the increase of desoxyribonucleic acid in the developing embryo. Rapidly dividing cells and gland cells have high concentrations of both types of nucleic acids, but especially of ribonucleic acid. Nucleoproteins, important in cytoplasmic synthesis, are influenced by genetic changes in the chromosomes. An increase of thymonucleic acid at heterochromatic regions of the chromosome increases the concentration of cytoplasmic nucleic acids (Painter).

Nuclear enlargement, increased basophily, greater number of nucleoli, and larger chromosomes have been generally reported as being characteristic of the nuclei of cancer cells. This has been explained by Biesele as being the result of growth and division of chromosomes without a breakdown of the nuclear wall or division of the cell as a whole (endomitosis). He further states that the frequency of endomitosis and the relative abundance of nucleic acids in a tumor seem to be proportional to the degree of malignancy of the tumor. Larger amounts of ribonucleic acid in the cytoplasm of human tumor cells than in corresponding normal cells have been reported.

Sodium nucleinates, particularly sodium ribonucleinate, significantly increase rates of growth in tissue cultures, and it has been suggested that ribonucleic acid may be an important factor in the proliferation of cells in wound healing. This possible relation to cancer cell proliferation is provocative. The evidence indicates that there is a disturbance of nucleic acid metabolism in the tumor cell.

Dr. F. Schlenk, biochemist at the M. D. Anderson Hospital, reviewed "Studies on Amino Acid and Nucleotide Metabolism":

Amino acids are the building stones for protein synthesis in normal and neoplastic tissue growth. Some of them have to be ingested with the diet, while others can be formed in the body from materials ordinarily available. One of the reactions in amino acid synthesis is enzymatic transamination. From an amino acid and a keto acid another amino acid can be made by enzymatic shift of the amino group. Glutamic-aspartic acid transaminase was studied in this institute. It proved to consist of a large protein moiety and a prosthetic group which was recognized as a derivative of vitamin B_6. This explains the need of higher organisms for this vitamin which is necessary for tissue growth and maintenance.

As important as proteins are nucleotides for cellular metabolism and growth. The constituents of nucleotides are purine or pyrimidine bases, pentose (ribose or desoxyribose), and phosphoric acid. We are rather well informed about the metabolism of the purines, but the origin and fate of ribose has so far remained obscure. Recent studies at the Anderson Hospital have shown that phosphorylations of ribose and rearrangement of the phosphate groups occur in a fashion similar to hexose metabolism. This gives hope to elucidate and eventually to control the abnormal nucleotide metabolism in malignant tissues which was described in the preceding paper.

MEDICAL OFFICERS RETURNING TO TEXAS*

(Corrections: Bucky L. Burditt, formerly of Dallas, has returned to Del Rio; Robert Hall Johnson, formerly Hamlin, to Snyder; Harl D. Mansur, Jr., formerly Big Spring, to Ardmore, Okla.; Willard B. Morell, formerly San Antonio, to Pendleton, Oregon; S. Perry Post, formerly Boerne, to San Antonio; and Edward S. Ross, listed Denison, to Dallas.)

NAME	Serv.†	Location	Release Date
Armstrong-Donley-Childress-Collingsworth-Hall Counties			
1. Jones, Elmer K.	A	Wellington	
Bell County			
11. DeBord, Bert A., Jr.	A	Temple	
Bexar County			
89. Dimmitt, Dean P.	A	San Antonio	
90. Dreibrodt, Ben A.	A	San Antonio	
91. Dufner, Romie M.	A	San Antonio	
92. Powell, J. C., Jr.	A	San Antonio	
Bosque County			
2. Shipp, John R.	A	Cranfills Gap	
Caldwell County			
3. DuBoise, Otho K.	A	Lockhart	
Cass-Marion Counties			
2. Brooks, Jesse M.	A	Atlanta	
Cherokee County			
3. Evans, Charles W., Jr.	A	Fastrill	
Clay-Montague-Wise Counties			
2. Mood, Francis A.	A	Nocona	
Comal County			
1. Bergfeld, A. W. C.		New Braunfels	
2. Karbach, H. E.	N	New Braunfels	
Coryell County			
2. Lowrey, Ernest E.	A	Gatesville	
Dallas County			
131. Alfieri, Anthony L.	A	Dallas	Mar., 1946
132. Block, Harold M.	A	Dallas	
133. Coggeshall, Howard C.	A	Dallas	
134. Freed, Harold	A	Dallas	
135. Leeper, Edward P.	A	Dallas	
136. Littell, George S.	A	Dallas	
137. Lyday, Victor I.	A	Dallas	
138. Simonson, Sigwert W.	A	Dallas	
El Paso County			
36. Basom, William C.	A	El Paso	
37. Breck, Louis W.	A	El Paso	
38. Readinger, Ivan H.	A	El Paso	
39. Snidow, Francis A.	A	El Paso	
40. Villareal, Leopoldo	A	El Paso	
Erath-Hood-Somervell Counties			
2. Barekman, W. H.	A	Stephenville	
Galveston County			
40. Griffin, Harold B.	A	Galveston[1]	
Harris County			
185. Asher, Harvey	A	Houston[2]	
186. Austraw, Henry H.	A	Houston	
187. Crawford, Ralph C.	A	Houston	
188. Dickens, W. M.	A	Houston	
189. Kaminsky, Peter B.	A	Houston[3]	
Harris County—Continued			
190. McKay, Haden E.	A	Humble	
191. Singleton, P. C. A.	N	Houston	Mar., 1946
Jefferson County			
42. Curry, D. W.	A	Port Arthur	Feb., 1946
Kerr-Kendall-Gillespie-Bandera Counties			
6. Ivey, Hubert T.	A	Legion	Feb., 1946
Kleberg-Kenedy Counties			
3. Mitchell, R. H.	A	Kingsville[1]	
Lamb-Bailey-Hockey-Cochran Counties			
3. Williams, Edward S.	N	Levelland	Jan., 1946
La Salle-Frio-Dimmit Counties			
4. Meyers, C. P.	A	Cotulla[2]	
Lavaca County			
5. Gray, Willis J.	A	Moulton	
Lubbock-Crosby Counties			
15. Jenson, Alfred J.	A	Lubbock	
McLennan County			
24. Jaworski, H. L.	A	Waco	May, 1946
25. Jenkins, Joseph N., Jr.	A	Waco	
Nacogdoches County			
3. Taylor, James G., Jr.	A	Nacogdoches[3]	May, 1946
Nueces County			
25. Gill, James P.	A	Corpus Christi	
26. Yeager, Franklin W.	A	Corpus Christi	Feb., 1946
Palo Pinto-Parker Counties			
7. Logsdon, Charles P. C.	A	Palo Pinto	
8. Wright, Harry E.	A	Mineral Wells	
Potter County			
19. Hooper, John M.	A	Amarillo[4]	Apr., 1946
20. Wyatt, Malcolm H.	A	Amarillo	
Randall-Deaf Smith-Parmer-Castro-Oldham Counties			
4. Conventry, William V.	A	Farwell[5]	
Reeves-Ward-Winkler-Loving-Culbertson-Hudspeth Counties			
3. Hanes, L. C., Jr.	N	Winkler	Mar., 1946
San Patricio-Aransas-Refugio Counties			
6. Koch, Alvis A.	A	Ingleside	
Tarrant County			
59. Borough, Lester D.	A	Fort Worth	
60. Crawford, William M.		Fort Worth	
61. Lindsey, David C.	A	Fort Worth	
62. McDonald, R. P.	N	Fort Worth	
63. Renshaw, Horace S.	A	Fort Worth	
64. Sheddan, Frank G., Jr.	A	Fort Worth	
Taylor-Jones Counties			
16. Hooks, Jim M., Jr.	A	Abilene	
17. Middleton, Edwin E.	A	Abilene	
Tom Green-Coke-Crockett-Concho-Irion-Sterling-Sutton-Schleicher Counties			
10. Gray, George A.	A	San Angelo[6]	
Travis County			
25. Frobese, Alfred S.	A	Austin	
26. Hahn, W. Burford	A	Austin	
27. Herrod, James H.	A	Austin	
28. Jordan, Robbie C.	A	Austin	
Wichita County			
12. Bohmfalk, Stanley W.	A	Wichita Falls	
13. Pierce, Alexander W.	A	Wichita Falls	
14. Rosenblatt, W.	A	Wichita Falls	
Williamson County			
5. Buchholz, Ransom R.	A	Georgetown	

*EDITOR'S NOTE: This list is the seventh of a series in which it is hoped to name all those physicians who have been in the Armed Forces during the war just passed and have now returned to Texas to resume civilian practice. The information in this list has been assembled from a variety of sources. While an attempt has been made to secure as complete and as accurate data as possible, we are aware that omissions and errors have been made. Not only for publication in the JOURNAL but also for the permanent records in the central office of the State Medical Association, we invite and urge correction of and addition to the material here submitted. Note that physicians from each county area are numbered consecutively following those listed in the April JOURNAL; the last number in each section therefore indicates the total physicians returned to that county area. The complete total for Texas named to date (April 25), including the accompanying list, is 1,155.

† A=Army; N=Navy; U=U. S. Public Health Service.

[1]Formerly of Fort Worth.
[2]Formerly of Crockett.
[3]Formerly of Dallas.
[4]Formerly of McKinney.
[5]Formerly of Temple.
[6]Formerly of Abilene.

HOSPITALS NEEDING INTERNS AND RESIDENTS

Methodist Hospital, Dallas. Capacity 206 beds. C. B. Fielder, Superintendent; (4 interns now).

Brackenridge Hospital, Austin. Capacity 225 beds. J. M. Coleman, M. D., Medical Director; (2 interns, July 1).

El Paso City County Hospital, El Paso. Capacity 192 beds. George W. Cook, Col., U. S. A., Ret., Superintendent; (3 interns for one year term, graduates of class A medical schools only, July 1).

MISCELLANEOUS

COMING MEETINGS AND CLINICS

State Medical Association of Texas, Galveston, May 6-9, 1946. Dr. H. F. Connally, Waco, President; Dr. Holman Taylor, 1404 W. El Paso St., Fort Worth, Secretary.

American Medical Association, San Francisco, July 1-5, 1946. Dr. Roger I. Lee, Boston, President; Dr. Olin West, 535 North Dearborn Street, Chicago, Secretary.

Southern Medical Association. Dr. M. Y. Dabney, Birmingham, Ala., President; C. P. Loranz, Empire Building, Birmingham, Ala., Secretary-Manager.

Southwest Allergy Forum. Dr. George W. Owen, Jackson, Miss., Temporary President; Dr. A. H. Braden, 1910 Crawford St., Houston, Secretary.

Texas Association of Medical Anesthetists, Galveston, May 6, 1946. Dr. E. D. Embree, Houston, President; Dr. R. A. Miller, 1415 Nix Professional Building, San Antonio, Secretary.

Texas Association of Obstetricians and Gynecologists, Galveston. Dr. Allen McMurrey, Houston, President; Dr. Julius McIver, 714 Medical Arts Building, Dallas, Secretary.

Texas Chapter American College of Chest Physicians, Galveston, May 6, 1946. Dr. S. E. Thompson, Kerrville, President; Dr. Elliott Mendenhall, Dallas, Secretary.

Texas Club of Internists. Dr. Robert M. Barton, Dallas, President; Dr. Julian C. Barton, 414 Navarro St., San Antonio, Secretary.

Texas Hospital Association. Tol Terrell, Harris Memorial Methodist Hospital, Fort Worth, President; Miss Madelyne Sturdavant, 5709 Velasco, Dallas, Secretary.

Texas Neuropsychiatric Association, Galveston, May 6, 1946. Dr. Titus Harris, Galveston, President; Dr. Fred Rogers, Dallas, Secretary.

Texas Ophthalmological and Otolaryngological Society, Dallas, December, 1946. Dr. C. B. Williams, Mineral Wells, President; Dr. E. D. Dumas, San Antonio, Secretary.

Texas Orthopedic Society. Dr. E. A. Cayo, San Antonio, President; Dr. Edward Smith, Houston, Secretary.

Texas Pediatric Society, Fort Worth, October, 1946. Dr. Max Woodward, Sherman, President; Dr. John E. Ashby, Dallas, Secretary.

Texas Public Health Association, Austin, May 27-28, 1946. Dr. Lewis Dodson, University of Michigan. Ann Arbor, Mich., President; Mr. E. W. Sudderth, Sanitary Engineer, Court House, Dallas, Secretary.

Texas Radiological Society, January, 1947. Dr. Herman Klapproth, Sherman, President; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secretary.

Texas Railway and Traumatic Surgical Association, Galveston, May 6, 1946. Dr. W. B. Reeves, Greenville, President; Dr. Ross Trigg, First National Bank Building, Fort Worth, Secretary.

Texas Society for Mental Hygiene. Dr. Jack R. Ewalt, University of Texas Medical Branch, Galveston, President; Mrs. Elizabeth F. Gardner, 1617 Watchhill Road, Austin 21, Executive Secretary.

Texas Society of Gastro-Enterologists and Proctologists, Galveston, May 6, 1946. Dr. James J. Gorman, El Paso, President; Dr. George M. Underwood, 4105 Live Oak Street, Dallas, Secretary.

Texas Society of Pathologists, Galveston, May 8, 1946. Dr. May Owen, Fort Worth, President; Dr. C. T. Ashworth, Southwestern Medical College, Dallas, Secretary.

Texas State Heart Association, Galveston, May 6, 1946. Dr. Victor E. Schulze, San Angelo, President; Dr. Walter B. Whiting, Wichita Falls, Secretary.

Texas Surgical Society, Dallas, October, 1946. Dr. G. V. Brindley, Temple, President; Dr. Walter Stuck, 1426 Nix Professional Building, San Antonio, Secretary.

Texas Tuberculosis Association, Houston, September 16-17, 1946. Dr. J. B. White, Amarillo, President; Miss Pansy Nichols, Austin, Executive Secretary.

Third Panhandle, District Medical Society, Lubbock, October 8-9, 1946. Dr. W. A. Carroll, Claude, President; Dr. George Powers, Amarillo, Secretary.

Fourth District Medical Society, Brady, November, 1946. Dr. H. L. Locker, Brownwood, President; Dr. Glenn H. Ricks, Brady, Secretary.

Fifth and Sixth, Southwest District Society. Dr. Phil A. Bleakney, Harlingen, President; Dr. C. W. Tennison, San Antonio, Secretary.

Seventh, Austin, District Society. Dr. Robert B. Morrison, Austin, President; Dr. M. I. Brown, Austin, Secretary.

Eighth, Ninth and Tenth Districts Medical Society, Brenham, April 17, 1946. Dr. J. T. Tadlock, Dayton, President; Dr. George W. Waldron, Medical Arts Building, Houston, Secretary.

Eleventh District Society, Palestine, October, 1946. Dr. L. L. Travis, Jacksonville, President; Dr. C. B. Young, Tyler, Secretary.

Twelfth, Central Texas District Society, Corsicana, July, 1946. Dr. Thomas G. Glass, Marlin, President; Dr. H. F. Connally, Jr., Waco, Secretary.

Thirteenth, Northwest District Society. Dr. A. L. Roberts, Fort Worth President; Dr. Joe R. Wise, 1212 W. Lancaster, Fort Worth, Secretary.

Fourteenth District Society, Gainesville, June 11, 1946. Dr. C. B. Thayer, Gainesville, President; Dr. V. L. Tuck, Sherman, Secretary.

Fifteenth, Northeast Texas, District Society, October, 1946. Dr. Frank Littlejohn, Marshall, President; Dr. Henry H. Neihuss, Greggton, Secretary.

CLINICS

Post Graduate Medical Assembly of South Texas, Houston, December 3-5, 1946. Secretary, 229 Medical Arts Building, Houston.

THE AMERICAN ASSOCIATION FOR THE SURGERY OF TRAUMA

San Antonio will be host to the American Association for the Surgery of Trauma on June 26, 27, and 28, according to Dr. Charles S. Venable, San Antonio, member of the Council of the Association. Headquarters will be at the Plaza Hotel, but the program on Thursday afternoon, June 27, will be held at the School of Aviation Medicine at Randolph Field.

Tentative arrangements for the program include the following speakers and subjects:

Dr. Alexander P. Aitken, Boston—Ruptured Intervertebral Disks in Industry.

Dr. James Barrett Brown, St. Louis—Military Plastic Surgery.

Dr. John A. Hillsman, Winnipeg, Canada (to be read by proxy) —Some Observations on Penetrating Wounds of the Heart.

Dr. Drury Hinton, Philadelphia—The Arrest of Spreading Gas Gangrene by Oxygen Injection.

Drs. E. S. Gurdjian and H. R. Lissner, Detroit—A Method for Studying Quantitatively the Relationship between the Amount of Force Applied and the Direction and Amount of Deformation in Skulls.

Dr. Cecil E. Newell, Chattanooga, Tenn.—Treatment of Intertrochanteric Fractures.

Dr. John Paul North, Wynnewood, Pa.—Localized Clostridial Wound Infection and Gas Gangrene.

Dr. A. William Reggio, Boston—Reconditioning or Rehabilitation—Which?

Dr. Robert L. Rhodes, Augusta, Ga.—Tenosynovitis of the Forearm.

Dr. Albert O. Singleton, Galveston—Surgical Wounds of the Abdominal Wall with Their Favorable and Unfavorable Results.

Dr. J. Huber Wagner, Pittsburgh—Bone Graft of Ununited Fracture of the Tibia, by Lateral Approach.

Dr. James Spencer Speed, Memphis, Tenn.—Reconstructive Procedures in Difficult Types of Ununited Fractures.

The School of Aviation Medicine will provide exhibits depicting the pathology in animals subjected to abrupt deceleration, a hospital catastrophe room, training aids in aviation medicine, air evacuation aircraft and equipment, and various types of aircraft, and a complete tour of the school has been scheduled. A formal program at the school will include a welcome from the commandant and the following papers:

Investigation of the Mechanism of Injury due to Abrupt Deceleration—Capt. Robert F. Rushner.

Injuries Commonly Encountered in Casualties Surviving Aircraft Crashes—Capt. Robert R. Nixon.

A Plan for the Care of Crash Casualties—Lt. Col. Randolph L. Clark.

BLOOD CLOTTING IN HEART DISEASE

A preparation of spoiled sweet clover has been used successfully to delay clotting of the blood in patients with coronary thrombosis. Three investigators, comparing an untreated group with a treated group of patients, found that this drug reduced the death rate.

Writing in the February 16 issue of *The Journal of the American Medical Association*, the three investigators—H. Raymond Peters, M. D., J. Roy Guyther, M. D., and Charles E. Brambel, Ph. D., of Baltimore—say that of the 60 patients treated in the usual routine manner with bed rest, 13 died. Of the 50 treated with dicumarol, the spoiled sweet clover drug, only two died.

These 110 cases were studied during the last three years at Mercy Hospital in Baltimore. The investigators are from the Departments of Medicine and Clinical Biochemistry, Mercy Hospital Division, University of Maryland School of Medicine.

In coronary thrombosis a clot forms in one of the coronary arteries, or more frequently in one of the branches, and a portion of the heart muscle is deprived of blood for a length of time sufficient to do damage. The seriousness of the accident depends on the size and location of the branch blood vessel which is stopped up by the clot.

The authors say that they observed an increased clotting tendency in most of their cases of acute coronary thrombosis. Dicumarol, which was discovered when hemorrhagic disease was studied in cattle, reduces the occurrence of complications by delaying the clotting of the blood.

In conclusion the authors say that the drug can be administered for an indefinite time as ill effects were not noted.

TEXAS SURGICAL SOCIETY

The Texas Surgical Society held its spring semi-annual meeting April 1-2 at the Kyle Hotel, Temple. Special guest speakers were Dr. Louis Byars, professor of plastic surgery, Washington University Medical School, St. Louis, and Dr. R. L. Sanders, professor of Surgery, University of Tennessee Medical School, Memphis.

The scientific program follows:

April 1

Wounds of the Heart—Asher McComb, San Antonio.
The Contact Splint—G. W. N. Eggers, Galveston.
The Diagnosis and Surgical Management of Cancer of the Colon—R. L. Sanders, Memphis, Tenn.
Papilloma of the Common Hepatic Duct (Case Report)—J. P. Barnes, Houston.
The Management of Burns—W. C. Tenery, Waxahachie.
The Early Rehabilitation of the Burned Patient—Louis T. Byars, St. Louis, Mo.
Reconstructive Procedures Used in an Army Plastic Center.
Part 1—Lt. Col. Thomas D. Cronin, Wakeman General Hospital, Camp Atterbury, Ind.
Part 2—Col. T. G. Blocker, Galveston.

April 2

Primary Sarcoma in the Gastro-Colic Omentum—Jack Furman, Fort Worth.
Breast Incisions: Anatomical, Rational and Aesthetic—John T. Moore, Houston.
Surgical Treatment of Hemifacial Spasm—James Greenwood, Houston.
A New Operative Treatment of Elephantiasis—Edgar J. Poth, Galveston.

In a business session it was decided to hold the fall meeting in Dallas the first week in October. Entertainment features included luncheon, a cocktail party, and a formal dinner on April 1.

Drs. C. M. Simpson, chairman; G. V. Brindley, and M. W. Sherwood formed the local arrangements committee.

STREPTOMYCIN FOR CIVILIAN USES

All civilian inquiries and requests for streptomycin are to be sent to Dr. Chester S. Keefer, Evans Memorial Hospital, 65 East Newton, Boston, Mass., under an allocation program recently announced by the Civilian Products Administration. Dr. Keefer is Chairman of the Committee on Chemotherapeutic and Other Agents of the Division of Medical Sciences, National Research Council, and has been authorized to handle civilian requests, providing they are submitted by a physician giving sufficient technical information to enable him to decide whether streptomycin is indicated in the treatment of the case. Other agencies receiving allotments of the scarce drug include the Army, Navy, Veterans Administration, and the U. S. Public Health Service.

The CPA has announced that there will be no commercial distribution of streptomycin at this time, nor will the producers supply the drug directly for civilian requests. Physicians have been asked not to submit requests for streptomycin if the cases are susceptible to the action of the sulfonamides, penicillin, and other therapeutic agents.—S. G. O. Notes, March 15, 1946.

AMERICAN COLLEGE OF RADIOLOGY AND AMERICAN RADIUM SOCIETY

The American College of Radiology and the American Radium Society will meet in San Francisco, the former on June 29 and the latter on June 30 and July 1, announcements from the college indicate. This first annual meeting since 1944 will be held in the Palace Hotel, and persons who expect to attend are urged to arrange for reservations immediately. It is pointed out that the radiology meetings will be held immediately prior to the American Medical Association annual session, which opens in San Francisco on July 1.

GOVERNMENT-OWNED SURPLUS PROPERTY

Information regarding surplus property for sale through government agencies has been secured from the War Assets Administration and the U. S. Public Health Service. It is summarized below for the benefit of physicians who are veterans of World War II, nonprofit hospitals, and others who may be interested and who are eligible to purchase any of the available property.

Veterans Preference

A veteran, defined as any person who served in the active military or naval service on or after September 16, 1940, and before the end of the present war and has been discharged or released under honorable conditions (including persons on terminal leave or final furlough and those whose status has been changed from "active" to "inactive"), has third preference in the purchase of surplus government goods. Federal agencies have first preference; state and local governments second.*

To secure certification for preference, a veteran must take or send his discharge papers, terminal leave papers, photostatic or certified copies of such papers, or other proof that he is a veteran of this war to the nearest War Assets Administration office. In Texas, offices are located at 507 Mercantile Bank Building, Dallas; 1006 Electric Building, Houston; 1904 Transit Tower, San Antonio; 420 Caples Building, El Paso; and 817 Texarkana National Bank Building, Texarkana. Office hours are from 8:30 a. m. to 5:15 p. m., Monday through Friday.

The veteran must present to WAA a description of the business, profession, or employment in which the surplus government property will be used and a list of the kind and quantities of property which he wishes to purchase. Veterans are allowed preference only if they desire to purchase property which will be used to establish or maintain their own small business, professional, or agricultural enterprise in which more than 50 per cent of the invested capital or net income is owned by or accrues to a veteran or veterans, or if they are required by their employment to have their own tools and equipment.

Provided the above conditions are met, WAA will furnish a statement indicating that the veteran has preference rights to buy government surplus property and listing the kind and quantity of property desired. Actual purchase is carried out with the government agency holding surplus property.

*Editor's Note: An amendment to the Surplus Property Act, which became effective May 3, changed the order of preference for the purchase of surplus government goods. Various items including x-ray equipment, diathermy apparatus, operating tables, typewriters, desks, automotive equipment up through two and a half ton trucks (including passenger automobiles, jeeps, and small trucks), and other equipment necessary for establishing a medical practice or a business have been set aside for *exclusive* purchase by veterans of World War II, thus making available to them items previously made scarce through purchase by other persons and agencies. For items not set aside exclusively for veterans, the new order of preference is as follows: (1) federal agencies, (2) veterans of World War II, (3) Reconstruction Finance Corporation for use by small businesses, (4) state and local government agencies, (5) nonprofit and nontaxable institutions.

If the items he wishes to purchase are available when his preference certificate is presented to the disposal agency, the veteran is notified as to the location, price, and time allocated for inspection and completion of the sale. If not available, he is notified when the items do become available. Arrangements for purchase, payment, and delivery are made with the disposal agency.

The veteran may inspect the items he wishes to purchase, but all sales are on an "as is, where is" basis, with no warranty, expressed or implied, except as to title.

Veterans may buy for cash, or they may obtain credit directly from any loan agency selected, if they are qualified. Prices are fixed by the disposal agencies at a fair value which does not exceed the lowest price which is offered to commercial buyers and which is in accordance with OPA regulations.

The War Assets Administration establishes the minimum and maximum limits as to the value and quantity of property which may be purchased on preference by any veteran. The veteran may purchase up to $25,000 without any special approval. From $25,000 to $50,000, approval must be obtained from the Regional director. Anything over $50,000 must be approved by the Washington Office of the War Assets Administration. After exercising his preference he may nevertheless buy more, but in doing so he has no preference for the excess and is on the same level as other citizens. A veteran may purchase surplus property directly from the disposal agencies without exercising preference, if he is included in the class of buyers to whom the disposal agency is offering such property. Lists of inventories offered for preference purchase are available upon request to WAA.

Surplus property of the following types may be purchased by a veteran on preference: consumer goods (clothing, textiles, household and office equipment, automobiles, trucks, tires, hardware, surgical and medical equipment, photographic equipment, store fixtures, and so forth) and capital and producers goods (raw materials, machinery, transportation equipment, and so forth). He may not use his preference to buy real property or property for his personal use. An initial stock of property for resale within reasonable limits may be purchased on preference.

Disposal to Public Health Agencies

Eligible public health claimants are allowed a 40 per cent discount from the "fair value" of property available as surplus, fair value being defined as the lowest price prevailing at any trade level at the time of the transaction. State, county, and local health departments and units; state, county, and local sanitation departments and units; hospitals operated by nonfederal government agencies; nonprofit hospitals, clinics, and public health research organizations; nonprofit or tax supported schools of nursing, medicine, public health, dentistry, and pharmacy, and miscellaneous nonprofit groups organized primarily to promote the public health are eligible for the discount. If there is a question of eligibility, the fact of having been held tax-exempt under section 101(6) of the United States Internal Revenue Code is evidence of eligibility. The Public Health Service maintains a list intended to include the names of all claimants eligible for a discount, and applicants are invited to check with the public health specialist, War Assets Administration, Fort Worth, to be sure of their eligibility.

Regional offices of the War Assets Administration upon request will place names on the mailing list to receive lists of property available for sale. Separate offices are maintained for consumer goods (finished products ordinarily used by individuals or commercial establishments, including medical and hospital supplies, construction machinery, farm machinery, motor vehicles) and for capital goods (items used in industry and manufacture, and communication property). Claimants in Texas who wish to buy consumer goods should request notification of offerings suitable to their needs from the Agency Manager, War Assets Administration, Texas and Pacific Passenger Building, P. O. Box 1407, Fort Worth. Those interested in lists of capital goods available should inquire at the War Assets Administration regional offices at 2001 McKinney Avenue, Dallas; 1020 McKinney Avenue, Houston; or Transit Tower Building, South St. Mary Street at Billita Street, San Antonio. Inquiries concerning availability of surplus foods should be addressed to the U. S. Department of Agriculture, Production and Marketing Administration (Attention: Surplus Property), Washington 25, D. C. All requests for lists of available property should specify the particular classes of goods in which the applicant is interested.

To buy consumer goods listed as available by the disposal agency, the claimant may use his usual purchase order form in quadruplicate, drawn to the office of the disposal agency listing the property. It should request only items that appear in any one list and should be prepared according to sales conditions accompanying the offering by the disposal agency. On the body of the order the buyer should state, "Funds are available for the purchase of these items at fair value less 40 per cent." The disposal agency will normally accept only a formal purchase order. In emergencies, however, the disposal agency will accept a "letter of intent," indicating that the applicant is willing to purchase the specific items requested, to be followed at the earliest practicable date by the claimant's formal purchase order.

To buy capital goods, the claimant's usual purchase order form in quadruplicate may be used as outlined above, but the disposal agency will accept a letter of intent. It is not essential that capital goods requested be contained in a published list of available property.

In applying for a discount, the claimant should prepare in duplicate an application containing the following parts: (1) a request that a 40 per cent discount be approved for the accompanying purchase order; (2) a statement that "the applicant represents and warrants that it is an instrumentality or a nonprofit institution as defined in SPA Regulation 14, that the property ordered in the attached purchase document is required for its own use and to fill its own existing need for carrying on medical, public health, or sanitation activity, that the property will not be resold within one year of the date of the purchase without the consent in writing of the disposal agency"; (3) a statement which will show the ways in which and the extent to which the public health will be benefited by the applicant's use of the property being ordered, including how and to what extent the volume or quality of service will be increased and why the area served by the claimant needs such an increase; and (4) signature and title of a responsible official.

The two copies of the application for discount and the four copies of the purchase order or letter of intent to purchase should be taken or sent to the Special Representative, U. S. Public Health Service, % War Assets Administration, Texas and Pacific Passenger Building, P. O. Box 1407, Fort Worth. If on the basis of eligibility and need the discount is authorized, the Public Health Service representative will send the order directly to the disposal agency to be filled or will return it to the claimant upon his request so that he may inspect or select property and present the order in person at the time of the sale.

Terms of payment are prescribed in conditions of sale issued by the disposal agency to accompany offerings of property.

To purchase items listed in the Surplus Reporter, which covers items located outside of the State of Texas, the purchase order and application for discount should be prepared as described above, but the order should be sent direct to the office serving the territory in which the item is located. Do not put on the same purchase order items listed as available in the Seattle Region, the Chicago Region, and the Kansas City Region.

The capital goods offices at Dallas, San Antonio, and Houston are being staffed to handle consumer goods (which includes medical and hospital items) and the Fort Worth office will make allocations to these offices. Just how soon the change over will become effective is a matter of conjecture, but it will probably be within two or three months.

LICENSING OF HOSPITALS PROPOSED

To protect the public and hospitals themselves from poor services and inadequate facilities, state licensing of all general hospitals was proposed to officers of hospital organizations by Dr. Charles Wilinsky, administrator of Beth Israel Hospital in Boston and chairman of the American Hospital Association's Committee on Model Licensure Law. Representing hospitals in the United States and Canada, through state, regional, and provincial hospital associations, the group met to discuss problems and exchange ideas in the Mid-Year Conference of the Association in Chicago February 8 and 9.

"Ten states now have licensing laws for general hospitals," stated Dr. Wilinsky. "Six failed to pass similar laws in 1945. In many states, under prevailing conditions, almost any institution offering bed care may term itself a 'hospital.' The American Hospital Association, by formulating a model bill incorporating the best features of many laws now in force, hopes to encourage the adoption of general hospital licensing laws in all states. Such laws, to be effective, must be accompanied by a provision for adequate funds to provide regular hospital inspection by a competent staff of state or hospital personnel."

The care of veterans in community hospitals was voted all possible coöperation by the group. "Already several hundred hospitals in the nation have contracted with the Veterans Administration to care for male veterans with service-connected disabilities and for female veterans," said John N. Hatfield of Philadelphia, chairman of the Council on Government Relations. To facilitate immediate care for these men and women in their own communities and to ease the load on veterans hospitals, the Association has agreed to furnish as many as 20,000 civilian hospital beds by September, 1946. A resolution was passed approving the principle of utilizing an intermediary agency to handle the fiscal relationships between the Administration and the hospital rendering the service. The Michigan Hospital Service (Blue Cross) is performing this service in that state.

Resolutions proposing that hospitals make staff positions available to returning veteran physicians as soon as possible and urging the continued service of volunteers in civilian hospitals in view of sustained nursing shortages were passed by the group.

Employee pension plans, nurse relations, and the expansion of medical and Blue Cross voluntary prepayment plans were discussed among hospital and hospital association problems and progress.

HEALTH EDUCATION FELLOWSHIPS

Fellowships for one year of graduate study in health education, leading to a master's degree in public health, are being offered to qualified men and women by the U. S. Public Health Service through funds made available by the National Foundation for Infantile Paralysis. The training includes an academic course of eight or nine months and three months of supervised field experience in community health education. A stipend of $100 per month, plus tuition and travel expenses for the field experience, will be allowed.

Effective for the academic year starting in the fall of 1946, fellowships are open to men and women between the ages of 22 and 40, including veterans. Applications must be in the office of the Surgeon General, U. S. Public Health Service, Washington 25, D. C., not later than June 1 to be considered.

These fellowships are not available to employees of health departments, and the sponsors assume no responsibility for placing fellows in positions.

STATE MEDICAL BOARD EXAMINATIONS

The Texas State Board of Medical Examiners will hold an examination session in Dallas, June 11, 12, and 13, at the Baker Hotel, Dr. T. J. Crowe, secretary, has announced.

NICOTINE CONTENT OF CIGARS AND CIGARETS

"Thirty cigarets, weighing about one gram apiece and containing about 2 per cent nicotine in the tobacco, might contain just about the same amount of nicotine as six cigars weighing about 5 grams apiece and with the same nicotine content," the March 23, 1946, issue of *The Journal of the American Medical Association* says in answer to an inquiry. Continuing, *The Journal* says in part:

"About one fourth of the nicotine content of the tobacco may be expected to appear in the puffed smoke, though this figure may vary greatly, depending on the manner of smoking. Only about 12 per cent of the nicotine escapes with the exhaled smoke after inhalation, as compared with about 33 per cent after simple puffing without inhalation, but in either case the bulk of the nicotine appears to be deposited in the mouth or air passages. Accordingly, it might be possible for the thirty cigarets inhaled to yield about the same amount of nicotine absorption as the six cigars not inhaled.

"Since either cigarets or cigars may vary greatly in their nicotine content, however, and the latter especially may vary greatly in size, and both may be smoked at widely different rates and with the discarding of greatly different amounts of tobacco and retained constituents of the smoke in the unburned stumps, this conclusion required much caution. Moreover, much nicotine may be absorbed from the unburned stump of a cigar by the user who chews or sucks as he smokes, while on the other hand the habitual spitter may rid himself by expectoration of some of the nicotine taken in.

"The nicotine discussed is the chief factor found in cigaret or cigar smoke which may be expected to affect the normal heart, with the production of changes in rate and rhythm and even in electrocardiographic patterns in some cases. Carbon monoxide in the smoke would be greater in the cigar smoke than in the cigaret smoke but rarely sufficient to produce symptoms. The same is generally true of the other constituents of tobacco smoke."

POLISH INFANTS UNDERWEIGHT

The low standard of feeding in Poland has resulted in an average decrease of 30 per cent in the weight of newly born babies, according to a dispatch from the UNRRA Health Division representative in Warsaw. Added to this is the alarming fact that infant mortality has gone up from 12.4 per cent to 27 per cent and in some places near the German border, to 50 per cent.

The effect of malnutrition added to the conditions of life where whole families are crowded into a single room, often amid ruins, accounts for the rise of tuberculosis among children. In Warsaw, the

Pirquet test gave positive results in 84 per cent of the children, and 50 per cent of them were active cases. Tests have been carried out by the Ministry of Health in all the children's institutions, and although the incidence of the disease varied considerably in different localities, the general increase was substantially the same.

However, the number of clinics and orphanages in Warsaw has doubled in the last two months, and now there is some hope for such children. In most of the emergency homes for orphans and destitute waifs early last winter the only bedding was straw and there was no milk. Now, with extensive help from UNRRA supplies, children both in the institutions and in schools are given some food, warmth, and clothing.

Throughout Poland the Ministry of Health is conducting a drive to lower the infant mortality rate and the percentage of tuberculosis cases among children. Expectant mothers are being taught how to get the most value from the food available and how to care for themselves. Children are being fed in school, and used clothing, delivered by UNRRA, is distributed quickly and efficiently among them.

CHEST EXAMINATIONS OF DISPLACED PERSONS

Mobile x-ray units operated by UNRRA and the International Red Cross have begun a survey of chest conditions of the 400,000 displaced persons in UNRRA assembly centers in the U. S. Zone of Germany, according to information reaching United Nations Relief and Rehabilitation headquarters in Washington.

Two teams, consisting of a doctor and three Red Cross technicians, using UNRRA mobile microfilm x-ray units carried in ambulances, are making this survey, as a result of which UNRRA will be enabled to locate and treat individuals with tuberculosis. UNRRA hospitals in the U. S. Zone now have 1,000 beds for tuberculosis patients and more beds are on the way.

In addition to the mobile teams now operating, UNRRA is providing personnel and equipment for six semi-permanent microfilm stations in the zone and one x-ray unit is being set up for UNRRA personnel.

LITTLE DANGER FROM IMPORTED DISEASE

There is little or no risk of introducing foreign disease into the United States through returning military personnel from abroad, according to an announcement by the Office of The Surgeon General, which pointed out that the most careful estimates anticipate only moderate danger in a few cases. This conclusion was reached after a worldwide survey by the Interdepartmental Quarantine Commission, which was jointly established by the Secretaries of War and Navy and the Administrator of the Federal Security Administration to study this problem.

With the end of the war and return of the bulk of combat forces, it is now possible to review actual results on a preliminary basis. Though tentative, highly optimistic conclusions appear warranted, the announcement stated. To date no acute outbreak or secondary spread of an imported disease has been reported. While more slowly evident diseases may be identified later, it should be remembered that the traffic of war has gone on for four years, giving ample time for discovery of such diseases.

The 440,000 hospitalizations for malaria reported among Army personnel during the war fall short of pessimistic predictions for what has proved to be the commonest infectious disease of troops abroad. Even with the consideration that a portion of infected persons are liable to recurrence after their return to the States, conditions in this country are generally unfavorable for the spread of malaria and the chances of community risk are very small. The special danger of cholera, smallpox, plague, epidemic typhus, and yellow fever is a matter of historical record. Immunizations were employed against all these diseases by the Armed Forces along with water purification, environmental sanitation, and disinfestation and insect control. This preventive medicine program was exercised even under combat conditions and its effectiveness was shown by Army records. The high general level of sanitation, insect control, and alert medical care available here forms the final link in the protection of this country from imported diseases.

The risk of importing disease from abroad has been less in some respects than in normal prewar traffic and the credit for these results has been attributed to the modern preventive medicine program of the Army and Navy.

Cases of exotic disease did occur, the announcement stated, but extensive investigation of likely hazards and critical application of preventive and corrective measures were effective in reducing risks to small proportions.—S. G. O. Notes, March 31, 1946.

FLEA ANTIGEN BENEFICIAL

Flea antigen, a substance which produces immunity to flea bites, has benefited four out of five of the 129 susceptible infants and children treated on the West Coast, according to Alexander Hatoff, M. D., of Oakland, Calif.

Writing in the March 30, 1946, issue of *The Journal of the American Medical Association*, Dr. Hatoff, who is from the Department of Pediatrics of the Permanente Foundation Hospitals, says that the beneficial results consisted in a smaller size and shorter duration of the wheal and the decrease of irritation and of itching.

The flea antigen consists of an extract of the whole fleas of cat, dog, and human beings.

According to the report, the children's symptoms had continued unabated for a period of from one week to one year before treatment was begun. One hundred of the patients, or 78 per cent, were benefited. Six patients, or 5 per cent of the total, received a certain amount of benefit, and 23, or 17 per cent, failed to respond.

Dr. Hatoff states that in treating these patients, the average number of injections of flea antigen given was four. The average time of response following the initial injection was eight days.

In conclusion, the author says that the importance of this demonstration lies in the possibility that such a method might be used in conjunction with other measures for the control of insect borne diseases.

PENICILLIN TREATMENT OF OSTEOMYELITIS

In the future penicillin treatment of osteomyelitis will eliminate in some cases the marring and mutilation resulting from surgery, according to two investigators writing in the March 30, 1946, issue of *The Journal of the American Medical Association.*

Edwin J. Grace, M. D., from the Grace Clinic, Brooklyn, and Vernon Bryson, Ph. D., from the Biological Laboratory, Cold Spring Harbor, N. Y., say that the treatment consists of hospitalizing the patient for ten days during which injections of penicillin are administered every three hours, day and night, into the cavity which leads to the infected area of bone and into the muscles.

Certain measures must be taken, however, before this type of therapy can be employed, the authors state. The patients must have a complete physical examination with correction of any obvious deficiencies such as anemia or focal infections such as

tonsillitis. Bad teeth must be extracted and cavities filled.

Of the 7 chronic osteomyelitis patients who received this treatment, only 1 failed to respond. These patients had previously undergone a total of 91 operations without cure.

IRON DEFICIENCY ANEMIA

Iron deficiency anemia is frequently confused with vitamin B complex deficiencies, according to William J. Darby, M. D., of Nashville, Tenn., writing in the March 30, 1946, issue of *The Journal of the American Medical Association.*

Dr. Darby, who is from the Department of Medicine, Vanderbilt University School of Medicine, presents the case reports of 6 patients who showed no abatement of symptoms after treatment with B vitamins. These same patients were then treated with iron and almost immediate improvement was noted.

EYE BANKS FOR CORNEAL GRAFTS

Between 10,000 and 15,000 blind persons who need corneal graft operations can be helped by eye banks which are being established all over the country.

Writing in the May issue of *Hygeia*, Mrs. Henry Breckinridge, Executive Director of The Eye-Bank for Sight Restoration, Inc., in New York, says that the "purpose of this bank is to collect and preserve healthy corneal itssue from human eyes to be transplanted to blind persons who have lost their sight because of corneal defects." It is a nonprofit group.

Regretting that "at the present time, corneal tissue taken from a living or dead person may be stored for only three days before it is transplanted," the author states that "it is hoped that through research a prolonged method of preservation may be learned."

Although there are approximately 250,000 blind men, women and children in the United States, a corneal graft operation is successful only when the rest of the eye and optic nerve are normal.

A. M. A. COUNCIL REPORTS

COUNCIL ON PHARMACY AND CHEMISTRY

NEW AND NONOFFICIAL REMEDIES

The following additional articles, have been accepted as conforming to the rules of the Council on Pharmacy and Chemistry of the American Medical Association for admission to New and Nonofficial Remedies. A copy of the rules on which the Council bases its action will be sent on application.

AUSTIN SMITH, M. D., *Secretary.*

Contraceptive Jellies and Creams (See New and Nonofficial Remedies, 1945, p. 355).

The following articles have been accepted:

DUREX PRODUCTS, INC., NEW YORK

Lactikol Creme: A water dispersible nonfatty stearic acid and glyceryl monostearate cream, having a *p*H of 4.9, prepared from the formula:

	Per Cent
Stearic acid	15.00
Glyceryl monostearate	7.50
Glycerin	8.00
Glyceryl monoricinoleate	1.50
Sodium lauryl sulfate	0.50
Lactic acid	0.50
Perfume	0.07
Water sufficient to make	100.00

Actions and Uses.—(See article Contraceptive Jellies and Creams.)

Dosage.—5 cc.

Lactikol Jelly: A water soluble jelly formed from tragacanth, karaya and acacia, having a *p*H of 4.15, prepared from the formula.

	Per Cent
Tragacanth	2.70
Karaya	1.00
Acacia	1.00
Lactic acid	1.50
Glycerin	16.00
Glyceryl monoricinoleate	1.00
Sodium lauryl sulfate	0.20
Butyl ester of parahydroxy benzoic acid	0.02
Oxyquinolin sulfate	0.05
Perfume	0.04
Water sufficient to make	100.00

Actions and Uses.—(See article Contraceptive Jellies and Creams.)

Dosage.—5 cc.

Syringe Applicators for Contraceptive Jellies and Creams (See New and Nonofficial Remedies, 1945, p. 357).

The following articles have been accepted:

DUREX PRODUCTS, INC., NEW YORK

Lactikol Plunger Applicator: A transparent plastic tube threaded at the blunt intravaginal end to screw onto the tubes of Lactikol Creme and Jelly to permit filling by compression of the tube. The full capacity is 5 cc., the recommended dose.

Lactikol Metri-Dose Applicator: A transparent glass tube graduated to permit delivery of from 5 to 8 cc., slightly constricted at the intravaginal end to permit filling, and fitted at the distal end with a rubber compression bulb with central wire spring device to permit adjustment of the volume of jelly or cream to be delivered.

Thiamine Hydrochloride (See New and Nonofficial Remedies, 1945, p. 610).

The following additional dosage form has been accepted:

SCHIEFFELIN & CO., NEW YORK

Tablets Thiamine Hydrochloride: 3 mg.

Ascorbic Acid (See New and Nonofficial Remedies, 1945, p. 622).

The following additional dosage form has been accepted:

SCHIEFFELIN & CO., NEW YORK

Tablets Ascorbic Acid: 100 mg.

Hexestrol (See New and Nonofficial Remedies, 1945, p. 435).

The following dosage form has been accepted:

ORTHO PRODUCTS, INC., LINDEN, N. J.

Tablets Hexestrol: 1 mg. and 3 mg.

—J. A. M. A., Jan. 26, 1946.

Monomestrol.—Mestilbol.—Diethylstilbestrol monomethyl ether.—3-*p*-Hydroxphenyl-4-*p*-methoxyphenyl-3-hexene.—*a,a'*-Diethyl-4'-methoxy-4-stilbenol.—$C_{19}H_{22}O_2$ (Molecular weight 282.37). Monomestrol may be prepared by methylation of diethylstilbestrol or by partial demethylation of the dimethyl ether of diethylstilbestrol. The crude product may be purified by distillation in vacuum and recrystallization from water-alcohol or from benzene-petroleum ether mixtures.

Actions and Uses.—Monomestrol is used for the same conditions for which estrogenic substances are employed, and the contraindications are essentially the same. Like other estrogens, it must be individualized since each patient presents special problems. Patients undergoing treatment should remain under constant medical supervision. Side effects are rare, but when they do occur they are usually mild, although in a few instances it may be necessary to reduce the dosage temporarily.

Dosage.—The average oral dose for the treatment of menopausal symptoms is 0.5 to 1 mg. daily by mouth, although if necessary 10 to 25 mg. may be given parenterally biweekly. Dosage for atrophic genital disorders such as kraurosis vulvae include

1 to 5 mg. daily by mouth or 25 mg. weekly by parenteral injection; for gonorrheal vaginitis of children 0.25 mg. daily; for the prevention of breast engorgement 5 to 10 mg. daily or 25 mg. the first and third days by injection; for suppression of lactation 10 mg. two or three times daily, or 25 mg. daily by injection; for prostatic cancer 2.5 mg. three times daily by mouth. The duration of treatment varies and may last for several months or even two or three years in the treatment of the menopause, a few weeks for gonorrheal vaginitis in children, a few months for atrophic genital disorders, three to five days for prevention of breast engorgement and suppression of lactation or be continuous for prostatic cancer.

Tests and Standards.—

Monomestrol occurs as an odorless, white, crystalline powder, which melts at 116-117.5 C. when recrystallized from benzene-petroleum ether (112-114 C., when recrystallized from alcohol). It is soluble in alcohol, freely soluble in acetone and in ether and practically insoluble in water, in dilute mineral acids and in dilute aqueous solutions of sodium and potassium hydroxide. It may be dissolved in vegetable oils and in dilute solutions of sodium or potassium hydroxide in 50 per cent ethanol.

To 1 mg. of monomestrol dissolved in 5 cc. of alcoholic potassium hydroxide add diluted hydrochloric acid to neutralize the solution and then add 1 cc. in excess. Add 1 cc. of molybdophosphotungstate reagent and shake. Allow to stand ten minutes, dilute to 25 cc. with water and add 5 cc. of saturated sodium carbonate solution: a blue color develops on standing. Add a few drops of 50 per cent solution of antimony pentachloride in dry *alcohol-free* chloroform to a dilute solution of monomestrol in the same solvent: a red colored solution is produced which changes rapidly to purple *(distinction from hexestrol, which gives no color).*

Dissolve 10 mg. of monomestrol in 5 cc. of concentrated sulfuric acid: an orange color is produced which disappears on dilution with water *(distinction from hexestrol and benzestrol, which give no color).*

Dry an accurately weighed specimen of monomestrol at 100 C. for four hours: the loss does not exceed 0.5 per cent. Ignite an accurately weighed specimen of monomestrol after the addition of concentrated sulfuric acid: the sulfated ash residue is not more than 1 per cent.

Transfer 0.1 Gm. of monomestrol to a 100 cc. volumetric flask and dilute to the mark with carbon tetrachloride. Transfer 10 cc. of the solution to a 250 cc. iodine flask fitted with an accurately ground stopper; add the calculated quantity plus 1 cc. of tenth-normal bromidebromate solution (prepared according to the U. S. P. XII, p. 749); wash the walls of the flask and wet the stopper by the addition of 10 cc. of distilled water. Quickly add 10 cc. of 10 per cent hydrochloric acid and insert the wet stopper. Shake the mixture thoroughly for several minutes, then set aside in the dark at 30 C. and shake intermittently for exactly fifty minutes. At the end of this period place 2 cc. of 40 per cent potassium iodide solution around the stopper. Remove the stopper just enough to allow the potassium iodide solution to enter the flask, shake thoroughly, rinse the stopper and sides of the flask with distilled water, add 25 cc. of carbon tetrachloride and titrate with fiftieth-normal sodium thiosulfate to the disappearance of the pink color in the carbon tetrachloride. Each cubic centimeter of tenth-normal bromide-bromate solution is equivalent to 4.706 mg. of monomestrol. The monomestrol content is not less than 99 per cent. *The nature of the reaction between bromine and monomestrol leads to complications unless the conditions of a given procedure are strictly observed. This method of standardization must be considered tentative until more accurate analytic procedures are available.*

The following dosage forms have been accepted:

WALLACE & TIERNAN PRODUCTS, INC., BELLEVILLE, N. J.

Tablets Monomestrol: 0.25 mg., 0.5 mg., 1.0 mg., 2.5 mg. and 5.0 mg.

Solution Monomestrol 10 mg. and 25 mg. per cc. (in Sesame Oil): 1 cc. ampuls.

Procaine Hydrochloride (See New and Nonofficial Remedies, 1945, p. 97).

The following dosage form has been accepted:

GEORGE A. BREON & CO., INC., KANSAS CITY, MO.

Solution Procaine Hydrochloride 2% W/V: 30 cc. vials. Each cubic centimeter contains 20 mg. procaine hydrochloride in isotonic solution of sodium chloride with chlorobutanol 0.5 per cent as a preservative.

Pertussis Vaccine Combined with Diphtheria Toxoid (See J. A. M. A., Jan. 5, 1945, p. 31.)

The following dosage form has been accepted:

PARKE, DAVIS & CO., DETROIT

Diphtheria Toxoid-Pertussis Vaccine Mixed (Sauer): 6 cc. vials (one immunization) and 24 cc. vials (four immunizations).

—J. A. M. A., Feb. 23, 1946.

Procaine Hydrochloride (See New and Nonofficial Remedies, 1945, p. 97).

The following additional dosage forms have been accepted:

THE WM. S. MERRELL CO., INC., LOESER LABORATORY DIVISION, NEW YORK

Solution Procaine Hydrochloride 1% W/V: 30 cc. and 100 cc. Each cubic centimeter contains procaine hydrochloride 10 mg. in isotonic solution of sodium chloride with chlorobutanol 0.5 per cent as a preservative.

Solution Procaine Hydrochloride 2% W/V: 30 cc. and 100 cc. Each cubic centimeter contains procaine hydrochloride 20 mg. in isotonic solution of sodium chloride with chlorobutanol 0.5 per cent as a preservative.

Pertussis Vaccine Combined with Diphtheria and Tetanus Toxoids (See J. A. M. A., Jan. 5, 1946, p. 31.)

The following dosage form has been accepted:

SHARP & DOHME, INC., GLENOLDEN, PA.

Diphtheria-Tetanus-Pertussis Antigens Combined, Alum Precipitated: One 3 cc. vial (one 3 dose immunization) and one 10 cc. vial (three 3 dose immunizations). Preserved with phenylmercuric nitrate 1:50,000.

Diethylstilbestrol (See New and Nonofficial Remedies, 1945, p. 428.)

CARROLL DUNHAM SMITH PHARMACAL COMPANY, ORANGE, N. J.

The following dosage forms have been accepted:

Diethylstilbestrol (in Peanut Oil): 1.0 mg. per cc.: 1 cc. ampuls.

Tablets Diethylstilbestrol: 0.1 mg., 0.5 mg., 1.0 mg., and 5.0 mg.

Penicillin (See New and Nonofficial Remedies, 1945, p. 214).

The following dosage form has been accepted:

WINTHROP CHEMICAL CO., INC., NEW YORK

Penicillin Calcium: Vials containing 100,000 or 200,000 units.

—J. A. M. A., Mar. 2, 1946.

Percomorph Liver Oil (See New and Nonofficial Remedies, 1945, p. 637).

The following additional dosage form has been accepted:

MEAD JOHNSON & COMPANY, EVANSVILLE, IND.

Oleum Percomorphum with Other Fish Liver Oils and Viosterol: 10 cc. bottles.

Mannitol Hexanitrate (See New and Nonofficial Remedies, 1945, p. 334).

The following dosage form has been accepted:

E. R. SQUIBB & SONS, NEW YORK

Tablets Mannitol Hexanitrate: 16 mg. and 32 mg.

Gold Sodium Thiosulfate (See New and Nonofficial Remedies, 1945, p. 175).

The following additional dosage form has been accepted:

MERCK & CO., INC., RAHWAY, N. J.

Gold Sodium Thiosulfate: 75 mg. bottles.

Thiamine Hydrochloride (See New and Nonofficial Remedies, 1945, p. 610).

The following additional dosage form has been accepted:

MEAD JOHNSON & COMPANY, EVANSVILLE, IND.

Tablets Thiamine Hydrochloride: 5 mg.

Bacterial Vaccine made from Hemophilus Pertussis (See J. A. M. A., Jan. 5, 1946, p. 31).

The following dosage form has been accepted:

PARKE, DAVIS & CO., DETROIT

Pertussis Vaccine, Immunizing (Sauer): 6 cc. and 24 cc. vials. 15,000 million H. Pertussis per cubic centimeter.

Riboflavin (See New and Nonofficial Remedies, 1945, p. 614).

The following additional dosage form has been accepted:

ABBOTT LABORATORIES, NORTH CHICAGO, ILL.

Tablets Riboflavin: 10 mg.

Sulfathiazole Sodium (See New and Nonofficial Remedies, 1945, p. 213).

The following dosage form has been accepted:

ABBOTT LABORATORIES, NORTH CHICAGO, ILL.

Sterile Sodium Sulfathiazole Anhydrous: 5 Gm. ampuls.

Ascorbic Acid (See New and Nonofficial Remedies, 1945, p. 622).

The following dosage form has been accepted:

MCKESSON & ROBBINS, INC., BRIDGEPORT, CONN.

Tablets Ascorbic Acid: 25 mg., 50 mg. and 100 mg.

—J. A. M. A., Mar. 9, 1946.

CHLOROQUINE, NONPROPRIETARY NAME FOR SN 7618

The Board for Coördination of Malarial Studies has requested the Council on Pharmacy and Chemistry to give consideration to the recommendation of a nonproprietary name for a new antimalarial compound known so far as SN 7618. It has the chemical structure of 7 chloro-4 (4-diethylamino-1-methylbutylamino) quinoline. Chloroquine has been proposed as the nonproprietary name.

The Council has been informed that the compound is covered by a German patent which has been assigned to the Winthrop Chemical Company, although all of the work in developing its antimalarial properties and usage has been done by the government contractors working under the Office of Scientific Research and Development. The Council has been cognizant of the value of the coöperative studies which have been undertaken during the war. It feels that every effort should be made to encourage this and similar work and to make available as soon as seems expedient the results of the studies so that they may be applied for the good of humanity. The adoption and use of appropriate nonproprietary names for truly useful drugs would seem to be a step in this direction.

The Council has voted to recognize Chloroquine as a nonproprietary name for the antimalarial substance sometimes described as SN 7618.

—J. A. M. A., Mar. 23, 1946.

COUNCIL ON PHYSICAL MEDICINE

The Council on Physical Medicine has authorized publication of the following reports.

HOWARD A. CARTER, *Secretary.*

HOLMSPRAY ATOMIZER AND NEBULIZER ACCEPTABLE

Manufacturer: T. J. Holmes Co., Inc., Chartley, Mass.

The Holmspray Atomizer No. 605 is a device for applying medicaments to the nose and throat. It is an all glass atomizer adapted for spraying oils, aqueous solutions and alcoholic solutions, especially designed for disseminating compounds which affect metals or are affected by contact with metals. The device is equipped with a rubber bulb to create pressure and gives a direct, relatively heavy spray.

The Holmspray Nebulizer No. 630 is different from the Holmspray Atomizer in that it produces a finely disseminated, almost invisible vapor designed to reach more distant parts of the respiratory tract. Like the Atomizer, it is all glass and is designed for compounds which affect metals or are affected by contact with metals. It is equipped with a rubber bulb.

The Council on Physical Medicine voted to accept the Holmspray Atomizer No. 605 and the Holmspray Nebulizer No. 630 for inclusion in its list of accepted devices.

BELTONE MONO-PAC HEARING AID ACCEPTABLE

Manufacturer: Beltone Hearing Aid Company, 1450 W. 19th Street, Chicago 8.

The Beltone Mono-Pac Hearing Aid is a three tube instrument with transmitter, amplifier and batteries in one case. A single cord connected to an air conduction receiver is attached to the case.

Physical Dimensions:

Case: 5½ by $2\frac{9}{16}$ by 1⅛ inches.

Receiver: Either 1 inch diameter or ¾ inch diameter air condition crystal (Brush).

Weight:

Case (containing batteries, transmitter and amplifier): 11¼ ounces.

Current consumption:

A battery (1½ volts), 60 milliamperes.

B battery (30 volts), 0.68 milliampere.

Current drain is independent of volume control setting.

Acoustical gain for pure tones:

	250	500	1,000	2,000	3,000	4,000	5,000	F
Maximum gain, high tone	26.5	37.0	49.0	55.0	51.0	37.5	22.0	decibels
Maximum gain, medium tone	32.0	39.5	51.5	54.0	51.0	36.5	21.0	decibels
Maximum gain, low tone	29.0	35.0	39.5	49.0	41.5	25.5	8.0	decibels

These values were obtained with the large size crystal receiver (1 inch diameter). The measurements were obtained with an artificial ear. The instrument was mounted on a body baffle. These values do not represent absolute sound pressure values but indicate the amplification efficiency of the hearing aid at the different frequency levels shown. These values are accurate to within plus or minus 3 decibels.

Physical and Mechanical Features: The entire instrument, including batteries, is contained in a single case of black plastic material, rectangular with rounded edges. The combined volume control and "off-on" switch consists of a round knob positioned in an inset at the top of the case. The case is somewhat larger and heavier than the conventional tube hearing aid transmitter and amplifier case, since it also contains the batteries. The total weight, however, is less than that of the conventional instrument which has separate cases for transmitter and batteries.

Performance: This instrument operates in an entirely satisfactory manner. There is a minimum of inherent amplifier, case and cord noise.

The Council on Physical Medicine voted to include in its list of accepted devices the Beltone Mono-Pac Vacuum Tube Hearing Aid.

—J. A. M. A., Mar. 9, 1946.

COUNCIL ON FOODS AND NUTRITION

ACCEPTED FOODS

The following additional foods have been accepted as conforming to the Rules of the Council on Foods and Nutrition of the American Medical Association for admission to Accepted Foods.

JAMES R. WILSON, M. D., *Secretary.*

PREPARATIONS USED IN THE FEEDING OF INFANTS

(See Accepted Foods, 1939, p. 156)

Beech-Nut Packing Company, Canajoharie, N. Y.

Beech-Nut Junior Raisin Rice Pudding contains milk (raw-whole), dextrose, white rice, raisins, whole eggs, farina (enriched), salt and water.

Analysis (submitted by manufacturer).—Total solids 30.08%, moisture 69.92%, ash 0.87%, fat (ether extract) 1.45%, protein (N × 6.25) 2.42%, crude fiber 0.07%, carbohydrates (other than crude fiber) 25.27%, calcium 0.063%, phosphorus 0.068%, iron total 0.41 mg. per hundred grams, iron "available" (bipyridyl method) 0.40 mg. per hundred grams, copper 0.07 mg. per hundred grams.

Calories.—124 per hundred grams, 35 per ounce.

Vitamins.—	Per Hundred Grams
Vitamin A, total	114 U. S. P. units
Thiamine	0.023 mg.
Ascorbic acid	2.02 mg.
Riboflavin	0.106 mg.
Niacin	0.80 mg.

The Gerber Products Company, Fremont, Mich.

Gerber's Chopped Carrots.

Analysis (submitted by manufacturer).—Total solids 7.3%, protein 0.6%, fat (ether extract) 0.1%, crude fiber 0.6%, carbohydrates (by difference) 4.9%, ash 1.0%, calcium 0.025%, phosphorus 0.021%, iron 0.0009%.

Calories.—6 per ounce.

Vitamins.—

Vitamin A equivalent	12,500 I. U. per hundred grams
Thiamine	0.025 mg. per hundred grams
Riboflavin	0.037 mg. per hundred grams
Ascorbic acid	2.8 mg. per hundred grams

—J. A. M. A., Mar. 9, 1946.

LIBRARY NOTES

The package library consists of collections of reprints and other periodical material on various subjects, prepared for lending to members of the Association. Requests for packages should be addressed "Library, State Medical Association of Texas, 1404 W. El Paso Street, Fort Worth, Texas." Twenty-five cents in stamps should be enclosed with the request to cover postage and part of the expense of collecting the material. Only one package may be borrowed at a time, and packages are allowed to remain in the hands of the borrower for 14 days.

Package Service

Packages were mailed from the Library of the State Medical Association during April, as follows:

Providence Hospital, Waco—(1 journal); *Blood, potassium* (14 articles); *Thrombophlebitis, therapy* (11 articles); *Snake, bites* (6 articles); *Hernia, inguinal* (12 articles).

Dr. Jim Camp, Pecos—*Nasopharynx, cancer* (8 articles).

Southwestern Medical College, Dallas—(4 journals).

Dr. T. B. Reed, Mineola—*Tularemia* (13 articles).

Dr. Robert B. Wolford, Dallas—*Pneumoconiosis* (18 articles); *Dust* (14 articles).

Dr. J. D. Martin, El Paso—(5 journals).

Dr. Edgar Hutchings, Marlin—*Otomycosis* (7 articles).

Dr. Elliott Mendenhall, Dallas—*Bronchiectasis, therapy* (18 articles).

Dr. D. P. Dimmitt, Uvalde—*Paralysis, agitans* (13 articles); *Poliomyelitis, therapy* (7 articles).

Dr. J. Markewich, Houston—*Undulant Fever, therapy* (15 articles); *Blood, cholesterol* (14 articles).

Dr. F. T. McIntire, San Angelo—(6 journals).

Dr. John S. Bagwell, Dallas—*Nutrition, disorders* (11 articles); *Obesity* (26 articles).

Dr. F. B. Duncan, Amarillo—*Eyes, cancer* (10 articles).

Dr. Sidney W. Hughes, Brownwood—*Syphilis, therapy* (24 articles).

Dr. J. L. Moet, La Feria—*Fingers and Toes, dislocations* (2 articles).

Dr. B. L. Burditt, Del Rio—*Blood amylase* (5 articles).

Dr. A. Philo Howard, Houston—*Spine, intervertebral disk* (13 articles).

Dr. Holloway Bush, McKinney—*Arteriosclerosis* (7 articles); *Burns, therapy* (10 articles).

Dr. W. M. Boguskie, Hearne—(1 journal).

Capt. J. P. Gibson, Whipple, Ariz.—*Thyroid, diseases* (23 articles).

Dr. H. L. Wilder, Pampa—(4 journals).

Dr. Vernon A. Black, Wharton—(4 journals).

Dr. Ross Owens, San Antonio—*Blood, groups* (14 articles).

Dr. Wayne V. Ramsey, Abilene—(4 journals).

Dr. D. K. Robinson, Rocksprings—*Migraine* (19 articles).

Dr. S. L. Witcher, Clifton—*Anesthesia, procaine* (5 articles).

Dr. Clarence E. Gilmore, Paris—*Blood, groups* (10 articles).

Dr. A. B. Goldston, Amarillo—*Kidneys, cysts* (6 articles).

Dr. E. D. McDonald, Santa Anna—*Bursa, inflammation* (12 articles).

Dr. Thomas J. Williamson, Big Spring—*Anesthesia, pudental* (7 articles).

Dr. Bailey R. Collins, Wichita Falls—*Angina, Vincent's* (13 articles).

Dr. J. C. Terrell, Stephenville—*Colon, cancer* (26 articles).

Dr. J. P. McAnulty, San Angelo—*Thrombosis, mesenteric* (15 articles).

Dr. John D. Gleckler, Denison—*Condyloma* (8 articles).

Dr. R. H. Mitchell, Kingsville—*Coronary Vessels* (7 articles).

Dr. F. J. L. Blasingame, Wharton—*Licensure, medical* (4 articles).

Dr. Lamar C. Bevil, Beaumont—*Anesthesia, spinal* (12 articles).

Dr. J. E. Stover, Denton—*Cretinism* (12 articles).

Accessions

Philadelphia, Lea & Febiger—Soffer: Diseases of the Adrenals.

New York, Brooklyn Medical Press—The Venous Pulse and Its Graphic Recording.

Madison, The University of Wisconsin Press—Gillespie: Endotracheal Anaesthesia.

Baltimore, The Williams & Wilkins Company—Albrecht: Modern Management in Clinical Medicine.

New York, Grune & Stratton—Kalinowsky and Hoch: Shock Treatments and Other Somatic Procedures in Psychiatry.

Lawrence, Kan., University of Kansas Press—Barber: A Malariologist in Many Lands.

Springfield, Ill., Charles C. Thomas, Publisher—Macintosh and Mushin: Local Anaesthesia, Brachial Plexus; Steindler: The Traumatic Deformities and Disabilities of the Upper Extremity.

New York, D. Appleton-Century Company—Cunningham: Psychology for Nurses.

Philadelphia, W. B. Saunders Company—Mason and Zintel: Preoperative and Postoperative Treatment.

Washington, D. C., Federal Security Agency, U. S. Public Health Service—Illness and Medical Care Among 2,500,000 Persons in 83 Cities, with Special Reference to Socio-Economic Factors.

Baltimore, Collected Reprints from the Wilmer Ophthalmological Institute of the Johns Hopkins University and Hospital, Vol. VII, July 1942 to July 1945.

New York, Collected Reprints of the Grantees of The National Foundation for Infantile Paralysis, 1944, Volume V.

Summary

Reprints Received, 1,342	Local Users, 41
Journals Received, 275	Borrowers by Mail, 39
Items Consulted, 154	Packages Mailed, 51
Items Taken Out, 106	Items Mailed, 518

Total Items Consulted and Mailed, 778

MOTION PICTURE LENDING LIBRARY

Motion picture films on medical subjects, 16 mm., both silent and sound, some in color, and suitable for either medical or lay audiences, are available for loan to county medical societies, hospital staffs, or individual physicians, on request. Borrowers will be required to pay only the cost of shipment of the films, by express, with insurance, and for any damage to films while in the hands of the borrower.

Requests for films should be addressed to "Motion Picture Lending Library, State Medical Association of Texas, 1404 West El Paso Street, Fort Worth 3, Texas." A list of available films, with descriptions, will be furnished on request.

The following motion picture films were loaned by the Motion Picture Lending Library of the State Medical Association during April:

Choose to Live (Available through the courtesy of the United States Public Health Service and the American Society for the Control of Cancer)—Fort Worth Foodhandling Class, Health Center, Fort Worth.

From Moo to You (Available through the courtesy of the Borden Company, New York)—Fort Worth Foodhandling Class, Health Center, Fort Worth.

Know for Sure (Available through the courtesy of the Texas State Board of Health)—Fort Worth Foodhandling Class, Health Center, Fort Worth.

Malaria—Falls County Medical Auxiliary, Marlin High School, Rotary Club, Falls County Medical Society, Marlin.

Roentgen Pelvimetry (Available through the courtesy of Mead Johnson & Company)—Wichita County Medical Society.

NEWS

Contributions to this department will be appreciated. News should be of general medical interest, such as public health activities, new hospitals, personal items of more than local value, etc. News for a particular number of the JOURNAL should be in the hands of the Editor not later than the fifteenth of the preceding month.

A Shortage of Hospital Beds in El Paso was made still more critical with the closing of Masonic Hospital early in April to make way for construction of a Sears-Roebuck store, informs the El Paso *Times*. No new patients were to be accepted in the seventy-two bed, thirty-year-old hospital after April 1, a loss of 16 per cent of available hospital beds in the city, Dr. Russell Holt, president of the El Paso County Medical Society, said. Southwestern General Hospital had recently made available twenty additional beds when a wing closed for two years because of the nurse shortage was re-opened. Additional beds will be added to the wing soon, Dr. R. B. Homan, president of the board of managers of the hospital, indicated, and Southwestern also plans a fourth floor addition for obstetrics, releasing thirty-five more beds for general patients. When the Masonic Hospital closed its doors, however, only 383 beds were left in local hospitals.

A Five-Hundred Bed Veterans Hospital for Dallas has been authorized, the Frisco *Journal* quotes Col. T. G. Lanuhier, deputy administrator of the Veterans Administration, as saying. To be constructed near Southwestern Medical College, the new hospital will probably cost between $4,500,000 and $5,500,000.

The Brooke Army Medical Center demonstrated the use of blood plasma in battle in the Army Day celebration at Fort Sam Houston, April 6-9, according to the San Antonio *Light*. The medical center exhibited all the equipment of a clearing company, the most forward hospital and installation on a battlefield with the exception of first aid stations, explaining the steps by which dried plasma is used, treatment for wounded and injured soldiers suffering from shock, and oxygen apparatus. The medical center, recently reorganized as a training center, is now equipped to graduate 1,031 medical trainees every four weeks. As soon as additional housing is available, an increase will be made in the number of trainees being given eight weeks of basic training at the center.

The Texas Hospital Association at its meeting in Fort Worth, March 21-23, installed Tol Terrell, Harris Memorial Methodist Hospital, Fort Worth, as president, and elected the following new officers: Russell Nye, Dallas, president-elect; J. H. Felton, Lubbock, and D. S. Riley, Big Spring, vice-presidents; Oswald Daughety, Houston, treasurer; and William Bohman, Galveston, and George Buis, Austin, trustees.

A Second Annual Crippled Children's Clinic at College Station was held May 13 under the sponsorship of the Kiwanis Club, with the coöperation of the State Health Department, Brazos-Robertson Counties Medical Society, the County Health Unit, and other civic organizations, informs the Bryan *Eagle*. Dr. G. W. N. Eggers and four colleagues from the University of Texas Medical Branch examined without charge any crippled child under 21 years of age. Those found in need of medical attention and without financial ability to secure it were offered free treatment. State Vocational Rehabilitation Department representatives were also present to confer with older children in regard to eligibility for assistance on an educational program.

A Need for Additional Hospital Beds in Austin was emphasized in a report to the Chamber of Commerce by its health committee in March, the Austin *American* states. Reasons why more beds are needed were listed as an increase in Austin's population, the danger of epidemics, and the more extensive use of hospitalization insurance. The organization will urge the city to provide all possible money for hospital expansion and all private hospitals to expand their facilities whenever and wherever possible. In a report to the health committee, Dr. Ben Primer, director of the Austin-Travis County Health Unit, outlined plans for continuous training of food handlers in proper sanitation methods, pointed to the need for more adequate tuberculosis hospitalization and a photofluorographic unit for increased tuberberculosis case-finding, the need for hospital expansion, the need for a new building for the health and welfare departments, a program for the control of diarrhea in children and the use of DDT for fly control in areas of high incidence, and health education at both professional and lay levels.

A Tuberculin Testing Program at Austin High School was begun April 1 at the request of the Raymond L. Ditmar Science Club of the high school, informs the Austin *American*. The City-County Health Unit, State Health Department, and Travis County Tuberculosis Association coöperated to make the tests possible. They were conducted by Dr. Marjorie Ferrell, pediatric consultant of the State Health Department, assisted by two public health nurses and the executive secretary of the tuberculosis association. Several hundred students took the tuberculin test following an educational program presented by the tuberculosis association. The test was explained to students and a motion picture film on the subject was shown.

A Disease Affecting Cattle Handlers in Amarillo has been under investigation recently after approximately forty persons working in the stock yards and packing houses were stricken in March. Dr. John M. Hooper, Amarillo health officer, reports that the

illness was characterized by chills, high fever, sweats, and, in some cases that were studied by roentgen rays, some evidence of pneumonitis. Two persons died, apparently of the same illness, but the outbreak seemed to be limited to the groups mentioned, with no secondary cases having been reported about a month later.

Attempts to diagnose the disease were fruitless until three blood samples out of twenty-two taken by Dr. J. V. Irons, of the State Health Department, gave positive agglutination tests for "Q" fever. Investigations were still under way late in April by the State Health Department and the U. S. Public Health Service, as there were still many epidemiologic aspects of the outbreak that had not been studied. Additional blood samples were being collected from convalescent patients in the belief that additional support might be given to the diagnosis of "Q" fever as the cause of the outbreak, Dr. Hooper said.

University of Texas.—Dr. Wesley W. Spink, professor of medicine at the University of Minnesota, recently conducted a series of conferences on streptococcal and staphylococcal infections at the University of Texas Medical Branch, Galveston.

Dr. Charles A. Doan, professor of medicine and dean of the University of Ohio School of Medicine, was in Galveston the latter part of March, at which time he gave a series of clinics and conferences at the University of Texas Medical Branch on the function of the spleen in health and disease, and on acute blood disorders. Dr. Doan inspected the Children's Hospital and Psychopathic Hospital at the University in preparation for constructing children's and psychopathic hospitals at the Ohio school, which has received a grant of $5,000,000 for that purpose.

Cecil H. Cornell, D. V. M., formerly on the staff of Texas Agricultural and Mechanical College and recently a member of the Army Sanitary Corps, has been appointed assistant professor of preventive medicine at the University of Texas School of Medicine in charge of teaching and research in sanitation.

Thirteen members of the University of Texas Medical Branch staff attended the first postwar meeting of the American Physiology Society in Atlantic City, N. J., early in March, and several of them participated in the scientific program, according to the Galveston *Tribune*. Dr. Eric Ogden, professor of physiology, reported on recent studies at the medical school concerning factors causing high blood pressure. Dr. A. N. Taylor and Dr. D. W. Cowlings, of the physiology laboratories, explained stream flow of blood in the blood vessels. Dr. George Emerson, professor of pharmacology, and Dr. Paul Ewing, associate professor of pharmacology, proposed at the meeting that a standardized method of detailed study be used for the future experimentation on "ACS," the recently publicized Russian answer to prolongation of life. ACS was also discussed by Dr. C. M. Pomerat, professor of anatomy; Dr. Thurlo Thomas, assistant professor of anatomy; and Dr. Ludwik Anigstein, associate professor of tropical medicine. Dr. D. Bailey Calvin, professor of biological chemistry, and Dr. E. J. Poth, director of the Laboratory for Experimental Surgery, reported on the maintenance of nitrogen balance by feeding amino acids. Dr. W. A. Selle, professor of physiology, discussed the action of sugars on the liver. Dr. Arild Hansen, professor of pediatrics, and Dr. Hilda Wiese, research associate in pediatrics, told of effects of fat on metabolism.

A postgraduate conference in pediatrics at the University of Texas School of Medicine, with the Maternal and Child Health Division of the Texas State Board of Health coöperating, was held April 15-20. The guest speakers included Drs. John A. Anderson, University of Utah, Salt Lake City; Ralph Bowen, Baylor University, Houston; Daniel C. Darrow, Yale University, New Haven, Conn.; J. H. Park, Jr., Baylor University, Houston; Ralph Platou, Tulane University, New Orleans, La.; George Salmon, Baylor University, Houston; and A. V. Stoesser, University of Minnesota and Minneapolis General Hospital, Minneapolis, Minn., all pediatricians, and Dr. James Watt, surgeon at the U. S. Public Health Service quarantine station at Algiers, La. Approximately thirty members of the regular University staff also participated in the program of lectures, clinics, and discussions on a variety of subjects important to the health of children. Included among these subjects were allergy, hematologic disorders, diarrhea, poliomyelitis, rheumatic fever, meningitis, herpetic infections, pneumonia, congenital syphilis, prematurity, and mediastinal emphysema.

Personals

Dr. Lorence W. Feller has been named the outstanding young man in Fredericksburg during 1945 and was presented the distinguished service award of the Fredericksburg Junior Chamber of Commerce on March 12, according to the Fredericksburg *Standard*. Dr. Feller, president of Kerr-Kendall-Gillespie-Bandera Counties Medical Society during the past year, was commended for his aggressive civic and business leadership in the city, serving through civic clubs, the Girl Scout organization, his church, and other agencies.

Dr. James H. Baxter, assistant professor of medicine at Southwestern Medical College, has been awarded the Welch Fellowship in Internal Medicine for an initial period of three years beginning July 1, the Dallas *Times-Herald* reveals. The fellowship is administered by the Medical Fellowship Board of the National Research Council and is open to a limited number of United States physicians under 40 years of age who have demonstrated unusual aptitude and promise of outstanding achievement in internal medicine, teaching, and investigation.

Dr. A. O. Scarborough, Mineral Wells, has announced his retirement from practice after many years of service in West Texas, informs the Mineral Wells *News*. Dr. Scarborough is author of several books on medicine and early day practice, based on his own experience as a pioneer physician. Dr. and Mrs. Scarborough have gone to Snyder to spend the summer.

Dr. R. L. Cherry has resigned as associate director of public health and chief of the communicable disease division in San Antonio, effective April 15, to become chief medical officer of the inter-American field party in Bolivia, under the health and sanitary division of the Office of Inter-American Affairs, states the San Antonio *Light*.

Dr. Philip Magrish, San Antonio, in March joined the city health department as a clinician and will conduct a clinic session weekly at Mexican community centers, states the San Antonio *Light*.

Dr. and Mrs. J. J. Hinchman, Albany, have left for California to live, the Albany *News* informs. Dr. Hinchman, 78 years of age, practiced medicine fifty-three years, coming to Texas from Iowa in 1926.

Marriages

Dr. Jerome Olkin Ravel and Miss Marjorie Joanne Macow, both of Austin, were married there March 23. The couple will live in Galveston, where Dr. Ravel is a resident at John Sealy Hospital.

Dr. Joe A. Walker, Huntington, married Miss Gwendolyn Rawls, Wichita Falls, on March 29. Dr. Walker is serving an internship at the Medical and Surgical Memorial Hospital in San Antonio, where the couple will reside.

Births

To *Dr. and Mrs. L. J. Taubenhaus*, Houston, a daughter, Jair Ellen, on her father's birthday, December 29, 1945.

To *Dr. and Mrs. Donald Slaughter*, Dallas, a daughter, Virginia Iline, on February 1, 1946.

To *Dr. and Mrs. Cooper M. Connor*, Fort Worth, a daughter, Judith Elaine, on February 4, 1946.

To *Dr. and Mrs. Taylor T. Pickett*, Dallas, a son, on January 30, 1946.

To *Dr. and Mrs. W. C. Levin*, Galveston, a daughter.

To *Dr. and Mrs. Harvey C. Slocum*, Galveston, a daughter, Sarah Maltby, on February 7, 1946.

SOCIETY NEWS

Bell County Society

February 6, 1946

(Reported by O. B. Gober, Secretary)

Surgical Treatment of Conditions about the Feet—Harry B. Macey, Temple.
Medical Legislation—G. V. Brindley, Councilor, Twelfth District, State Medical Association, Temple.

Bell County Medical Society met February 6 at the Kyle Hotel in Temple with twenty-seven members and eight guests present. The scientific program outlined above was presented.

A letter from Raymond Gregory, director of the out-patient clinic at the University of Texas Medical Branch, Galveston, was read. He reported that during the past fifteen months, Bell County physicians had referred thirteen patients to the diagnostic clinic of the University's School of Medicine and John Sealy Hospital.

W. R. Metzger, S. W. Shibler, Jr., V. I. Lyday, and E. R. Veirs were accepted for membership upon application.

A resolution "seeking to improve the legal recognition with regard to medicine" was adopted.

Brazoria County Society

March 28, 1946

(Reported by A. O. McCary, Secretary)

Brazoria County Medical Society met March 28 at the Community House in Angleton with the Auxiliary and a group of dentists as guests.

J. E. Clarke, Houston, Councilor of the Ninth District, was present. He reported on the recent meeting in Fort Worth of the Executive Council of the State Medical Association, at which recommendations were made that physicians sponsor some form of health protection which could be administered locally and participated in voluntarily. Dr. Clarke stressed the importance of members of the medical society writing to their Senators and Representatives regarding medical legislation before Congress. Following his talk there was a general discussion of the proposed socialization of medicine.

G. J. Hayes, Alvin, moved that the society request a sample copy of the contract offered by Group Hospital Service, for study at the next meeting. President William Greenwood, West Columbia, requested the secretary to write the State Medical Association for a list of group insurance companies acceptable in Texas.

Brown-Comanche-Mills-San Saba Counties Society

March 11, 1946

Indications of Pneumothorax—David McCullough, Kerrville.
Indications and Results of Pulmonary Reception—Robert Shaw, Dallas.
Thoracoplasty—John S. Chapman, Dallas.

Brown-Comanche-Mills-San Saba Counties Medical Society met in Hotel Brownwood on March 11. Three visiting physicians, David McCullough, Kerrville; Robert Shaw, Dallas; and John S. Chapman, Dallas, presented the program outlined above, illustrating their talks with roentgenograms.

Denton County Society

April 4, 1946

Diseases of the Heart—Alex Terrell, Dallas.

Denton County Medical Society met in the office of M. L. Hutcheson, Denton, on April 4, with President William Magness, presiding.

Alex Terrell, Dallas, spoke on diseases of the heart.

Ector-Midland-Martin-Howard-Andrews-Glasscock Counties Society

March 28, 1946

(Reported by Edward H. Strauss, Secretary)

Socialized Medicine versus Voluntary Plans for Medical Insurance—R. B. G. Cowper, Big Spring.
The Use of Pins in Hip Fractures—J. E. Hogan, Big Spring.

Ector-Midland-Martin-Howard-Andrews-Glasscock Counties Medical Society met March 28 at the Settles Hotel in Big Spring, with sixteen members present. The Auxiliary joined the society for a chicken dinner and an extemporaneous talk by R. B. G. Cowper, Big Spring.

After members of the auxiliary had left the society heard a talk on the use of pins in hip fractures by J. E. Hogan, Big Spring, followed by a discussion by Drs. Cowper and Thomas.

It was announced that R. B. Anderson, Fort Worth, who had been scheduled to present the program, was unable to attend because of illness. A letter from B. E. Pickett, Carrizo Springs, chairman of the Library Endowment Committee of the State Medical Association, requesting donations for a new library building, was read.

Emmett V. Headlee, Odessa, was elected to the Board of Censors to replace John H. Barganier, Odessa.

Falls County Society

April 8, 1946

(Reported by J. W. Torbett, Sr., Secretary)

Falls County Medical Society met in the Blue Room of the Falls Hotel, Marlin, on April 8 for dinner. Following the meal, a motion picture on malaria was shown under the supervision of G. H. Hampshire, program chairman.

Galveston County Society

March 8, 1946

(Reported by John McGivney, Secretary)

Treatment of Battle Casualties in a General Hospital in France—Members of Surgical Service, 127th General Hospital.
Introduction—Robert M. Moore.
Soft Tissue Wounds—Hiram P. Arnold.
Compound Fractures—William H. Ainsworth.
Abdominal and Thoracic Wounds—Harold E. Griffin.
Neurosurgical and Maxillo-Facial Wounds—John C. Kennedy.

Galveston County Medical Society met March 8 in the Laboratory Building, University of Texas Medical Branch, Galveston, for the above scientific program and a business session.

A letter from Holman Taylor, Fort Worth, Secretary of the State Medical Association, requesting appointment of a committee to survey local hospital and medical service, was read. President Francis Garbade said the committee would be appointed in the near future.

Chauncey D. Leake, vice-president and dean of the Medical Branch of the University of Texas, by letter offered the facilities of the University to the Society, including in his invitation use of the library and research facilities and attendance on scientific programs of the faculty and staff meetings of John Sealy Hospital.

The society, upon suggestion by Joseph C. Magliolo, Dickinson, decided to write the American Red Cross that no donation as a society would be made as members customarily made contributions privately. A representative of the Red Cross had written soliciting a group donation.

Upon motion by Edward Thompson, seconded by William Spiller, the society endorsed a rat eradication program along the seawall, in accordance with a written request from Lt. Stephen P. Hatchett, director of the U. S. Public Health Service Typhus Control Unit operating in Galveston.

A letter from B. E. Pickett, chairman of the Library Endowment Committee of the State Medical Association, requesting donations to the library fund, was read and referred to the committee on economics.

Henry W. Poetter was accepted for membership by transfer from the Milam County Medical Society; Werner Hoeflich, from Harris County Medical Society.

Harris County Society

March 20, 1946

Recent Advances in Female Sex Hormones—Willard M. Allen, St. Louis, Mo.

Harris County Medical Society met March 20 in Houston to hear Willard M. Allen, chairman of the Department of Obstetrics and Gynecology of Washington University in St. Louis, speak on female sex hormones. Dr. Allen, author of more than sixty papers dealing with the subject, also addressed the Houston Society of Obstetricians and Gynecologists.

Hunt-Rockwall-Rains Counties Society

March 12, 1946

(Reported by Harriet Rogers, Secretary)

Regional Ileitis in a Female 29 Years of Age (Case Report)—Lowell H. Leberman, Commerce.
Cesarean Section—Joe Becton, Greenville.
Acute Pancreatitis—Leslie Bush, Greenville.

Hunt-Rockwall-Rains Counties Medical Society met in Greenville March 12 with seven members and two visitors present. The above scientific program was presented.

Joe Becton reported the indications for cesarean section as bony deformities, twins, eclampsia, placenta previa, premature separation, and heart complications. He discussed classical and low cervical types of cesarean section.

Leslie Bush discussed acute pancreatitis, reporting 4 cases with the symptoms of nausea, vomiting, acute abdominal pain, and shock. He presented the differential diagnosis of peptic ulcer, coronary thrombosis, cholecystitis, and appendicitis, and discussed other phases of the problem.

Drs. Leberman, Becton, and Harry M. Bradford participated in discussion of the papers.

Jefferson County Society

April 8, 1946

(Reported by L. R. Byrd, Jr., Secretary)

Clinical-Pathological Conference—John A. Hart, Beaumont.
The Control of Venereal Disease—T. A. Fears, Beaumont.

Jefferson County Medical Society met April 8 at Hotel Dieu, Beaumont, with L. R. Byrd, Jr., secretary, presiding in the absence of the president and the vice-president.

John A. Hart, Beaumont, conducted a clinical-pathological conference. He presented a case, which was discussed by L. T. Pruit, D. A. Mann, Norman Duren, J. J. Fertitta, S. T. Wier, and J. N. Gardner, of Beaumont, and B. B. Elster, of Port Arthur. S. J. Lewis, Beaumont, gave the summation and pathological picture.

T. A. Fears, Beaumont, discussed venereal disease, dealing with control measures, prevention, diagnosis, and treatment. He then presented an outline of the venereal disease education program for Jefferson County as proposed by him at the last meeting. W. A. Smith, H. B. Williford, Lamar Bevil, and E. H. Lindsey, all of Beaumont, discussed the presentation. L. C. Powell, Beaumont, moved endorsement of the venereal disease program. The motion was seconded by Dr. Bevil, and carried.

Dr. Fears read a letter from the Veterans Administration with reference to handling and care of veterans with service connected disability.

C. H. Todd, Jr., Beaumont, reported that the Municipal Dispensary planned to ask G. W. N. Eggers and his associates in Galveston to hold a crippled children's clinic and had requested approval of the society for such a plan. Upon motion by E. D. Mills, Beaumont, seconded by J. A. Bybee, Beaumont, approval was voted.

L. C. Heare, Port Arthur, and L. C. Powell, Beaumont, gave an account of the recent public relations conference held in Fort Worth in connection with the Wagner-Murray-Dingell bill, now pending in Congress. They pointed out the urgency of action aimed to defeat the measure, and upon motion by W. D. Brown, Beaumont, seconded by Dr. Gardner, the society adopted a resoloution introduced by Dr. Heare. This resolution placed the Jefferson County Medical Society on record as strongly opposed to passage of the Wagner-Murray-Dingell bill and requested the support of each of the Congressional members from the district in defeating the bill.

The society decided to follow the precedent set prior to 1942, when the dues of the secretary had been paid by the society, and agreed to refund to Secretary Byrd his expenditure for dues since 1944 and to pay his dues for 1946.

A letter of resignation from the society by S. Ross Jones, Port Arthur, was read. Dr. Jones indicated that he was retiring from medical practice because of ill health. Dr. Powell moved that the resignation not be accepted and that Dr. Jones be proposed for honorary membership in the State Medical Association. The motion was seconded by Dr. Heare, and carried.

Dr. Byrd reintroduced the problem of the failure of active members to pay the assessment voted by the society, contrary to the by-laws of the organization. After general discussion, the matter was referred to the society's attorney, J. B. Morris.

C. M. White, chairman; W. D. Brown, and D. A. Mann, all of Beaumont, were appointed to write resolutions on the recent death of Dr. Talbot A. Tumbleson, Beaumont.

Kerr-Kendall-Gillespie-Bandera Counties Society

March 8, 1946

Kerr-Kendall-Gillespie-Bandera Counties Medical Society officers met March 8 in Kerrville for a conference concerning public health legislation. R. B. Anderson, Fort Worth, chairman of the Committee on Public Relations of the State Medical Association; John H. Burleson, San Antonio, chairman of the Legislative Committee; Mr. Jeff L. Reese, Fort Worth, director of public relations; and C. E. Scull, councilor of the Fifth District, were visitors for the conference.

After the meeting, the Woman's Auxiliary was host for a buffet supper at the home of Dr. and Mrs. S. E. Thompson. Mrs. W. E. Gregg, retiring president, and Mrs. L. L. Keyser, incoming president, served at the table. Decorations included peach blossoms, bridal wreath, and hyacinths.

Lubbock-Crosby Counties Society

March 5, 1946

(Reported by Martin H. Benson, Secretary)

Diverticula of the Duodenum—A. G. Barsh, Lubbock.

Lubbock-Crosby Counties Medical Society met March 5 at the Hotel Lubbock with twenty-one members and one guest present. President A. G. Barsh presided.

It was decided upon motion by James E. Loveless, Slaton, and seconded by Robert H. McCarty, Lubbock, that physicians who had been military members of the society would be notified that they cannot be carried as members if they have severed their connection with military forces, unless they pay their dues.

The committee on x-ray investigation reported on the cost of an x-ray unit and the inability of the local hospitals to carry the required load. It was suggested that the city buy its own photofluoroscopic unit and hire a full time technician. No disposition of the problem was made.

Denzil D. Cross, Lubbock, president of the Panhandle District Medical Society, announced the spring

meeting of that organization in Amarillo on April 9-10.

A letter regarding the establishment of a medical laboratory in Lubbock was read, but no action was taken. Another letter from the Central Office of the State Medical Association regarding the need for doctors and hospitals in the locality was read and referred to the legislative and public relations committee.

Dr. Barsh discussed the history, incidence, relation to old age and sex, and pathogenesis of diverticula of the duodenum. He said that diagnosis is simple but can be accomplished only by roentgen examination. He mentioned the various symptoms and treatment, both medical and surgical. General discussion followed the presentation.

Nueces County Society

Nueces County Medical Society in coöperation with Memorial Hospital, Corpus Christi, is establishing a Nueces County Medical Library at the hospital. A trained medical librarian has already been employed full time.

C. D. Stewart, chairman; L. M. Garrett, C. L. Concklin, and Mr. Ross O. Urban, administrator of Memorial Hospital, are serving as a planning committee for the library. Some books have already been donated by local doctors, and funds to purchase additional books will be furnished by the sponsors. The library will be for the use only of members of the Nueces County Medical Society.

Smith County Medical Society

March 28, 1946

Smith County Medical Society was entertained March 28 by Dr. and Mrs. E. H. Vaughn, Tyler, at a buffet supper in the Blackstone Hotel Rose Room in Tyler, at which twenty-three physicians and dentists who were war veterans were the honor guests. Several brief talks on various phases of medicine and dentistry, particularly their advance during the war years, were given.

Physicians who served in the armed forces and attended the supper included E. N. Adams, Porter Bailes, Melvin R. Wilcox, Joe Golenternek, Dan Golenternek, Elbert H. Caldwell, Edwin G. Faber, Jesse Goldfeder, Masters H. Moore, Lex T. Neill, Leland R. Rhine, Herman C. Sehested, Jim Miller Vaughn, and W. O. Brown, the latter of Houston.

Tarrant County Society

April 2, 1946

(Reported by W. P. Higgins, Jr., Secretary)

The Management of Uretero-Pelvic Juncture Obstruction; Translumbar Arteriography As an Adjunct—A. K. Doss.

Tarrant County Medical Society met with thirty-one members and two visitors present in the Medical Arts Auditorium, Fort Worth, on April 2. The above scientific presentation was carried out, discussion being participated in by R. S. Mallard, Harold J. Shelley, and Hub E. Isaacks.

John J. Andujar introduced a motion which was seconded section by section and voted upon section by section. The motion, which was unanimously adopted in its entirety, proposed that the society go on record as strongly endorsing the principle of basic science legislation; favoring "complete legal, professional, and political separation from all cultists"; favoring "the principle of nonprofit, prepaid medical care for low income groups under the auspices or direct management of the State Medical Association"; and unalterably opposing socialized medicine "whether couched under the disguise of compulsory national health insurance or any other term."

In the absence of members of the by-laws committee, the secretary read and called for discussion on proposed changes in the by-laws of the society. He said that copies of the proposed changes would be mailed to members ten days in advance of the next meeting, at which time final action would be taken.

A letter from the Library Endowment Committee of the State Medical Association requesting donations was read.

Tribute was paid Mrs. H. W. Harper, mother of H. W. Harper, Jr., who died April 1.

Carl M. Austin was elected to membership upon application and Kenneth B. Walborn was accepted for membership by transfer from Dallas County.

Third (Panhandle) District Society

April 9-10, 1946

(Reported by George L. Powers, Secretary)

Third (Panhandle) District Medical Society met in Amarillo with headquarters at the Herring Hotel, April 9-10, with eighty-nine physicians registered. Nine supply houses and drug companies had exhibits.

In a business session W. A. Carroll, Claude, assumed the presidency; George L. Powers, Amarillo, was reelected secretary; and A. E. Winsett, Amarillo, was chosen president-elect. It was decided to hold the next meeting in Lubbock, October 8-9.

A luncheon and round-table discussion was held each noon of the meeting, and a banquet and dance was held the evening of the first day. The following scientific program was carried out:

TUESDAY, APRIL 9

President's Address—D. D. Cross, Lubbock.

Eye, Ear, Nose, and Throat Section

(R. A. Duncan, Amarillo, chairman; Fred J. Crumley, Amarillo, secretary)

Symposium on Headache:
- Headache from the Standpoint of the Otolaryngologist and Ophthalmologist—A. J. Streit, Amarillo.
- Headache from the Standpoint of the Internist—Harvey H. Latson, Amarillo.
- Discussion—F. B. Malone, Lubbock, and Evelyn G. Powers, Amarillo.

Section on Medicine

(Richard Keys, Amarillo, chairman; George M. Waddill, Amarillo, secretary)

The Decompensating Gastro-Intestinal Tract—Milford O. Rouse, Dallas.
- Discussion—Kenneth R. Flamm, Amarillo.

Rheumatic Fever—Wallace Sako, Galveston.
- Discussion—George M. Cultra, Amarillo.

Superficial Fungus and Certain Bacterial Infections of the Skin—J. G. Brau, Dallas.
- Discussion—Christopher C. Mansell, Lubbock.

Public Relations—E. A. Rowley, Amarillo.

WEDNESDAY, APRIL 10

Obstetrics and Gynecology Section

(Jason Robberson, Amarillo, chairman; D. S. Marsalis, Amarillo, secretary)

Benign Cervical Lesions—William F. Guerriero, Dallas.
- Discussion—O. W. English, Lubbock.

Frigidity—Sam Dunn, Lubbock.
- Discussion—Allen T. Stewart, Lubbock.

Technique of Thyroidectomy—Guy Owens, Amarillo.
- Discussion—Julius T. Krueger, Lubbock.

Surgery Section

(A. E. Winsett, Amarillo, chairman; R. R. Swindell, Amarillo, secretary)

Uses and Abuses of Colostomy—George R. Enloe, Fort Worth.
- Discussion—R. D. Gist, Amarillo.

Uses of Sulfasuxidine in Colon Surgery—Edward Crump, Wichita Falls.
- Discussion—W. R. Klingensmith, Amarillo.

Management of Uretero-Pelvic Juncture Obstruction; Translumbar Arteriography—A. Keller Doss, Fort Worth.
- Discussion—Sam K. Broyles, Amarillo.

Treatment of Fractures by Fixation—G. W. N. Eggers, Galveston.
- Discussion—D. S. Marsalis, Amarillo.

Eleventh District Society

March 29, 1946

(Reported by J. M. Travis, Secretary)

The Eleventh District Medical Society met in the Liberty Hotel, Jacksonville, on March 29. The society and the Woman's Auxiliary met jointly for dinner in the dining room of the hotel, during which time the Auxiliary furnished a program, consisting of a reading by Mrs. Arch Pearson, Jacksonville, and a piano solo by a student of Lon Morris College. Mrs. L. B. Windham, Tyler, responded to a welcome by Marvin Lamb, Jacksonville. The auxiliary then went to the home of Mrs. R. T. Travis.

The society in business session unanimously passed

a resolution introduced by J. M. Travis, Jacksonville, having to do with duties of the society officers. Another resolution, introduced by Dr. Travis and seconded by C. C. McDonald, Tyler, favoring maintenance of the hospital at Camp Fannin, was also unanimously adopted.

Leroy Trice, Palestine, called the attention of the society to the fact that A. L. Hathcock, councilor of the Eleventh District, was retiring from active practice and would not be a candidate for reelection. The society unanimously directed the Secretary to write a letter of appreciation to Dr. Hathcock for his past services.

L. L. Travis, Jacksonville, was elected president and Dr. Trice was elected vice-president, each to serve one year. C. B. Young, Tyler, was elected secretary-treasurer for four years. A Board of Directors will be appointed by the incoming president. Palestine was selected for the next meeting of the society in October.

John T. Moore, Houston, was invited to address the group, and the following scientific program was carried out:

Typhus Fever—George M. Hilliard, Jacksonville.
Discussion—E. G. Faber, Tyler.
The Treatment of Simple and Complicated Urinary Tract Infections—Hugh Rives, Houston.
Discussion—T. M. Jarmon, Tyler.
Recent Advances in Thoracic Surgery—Robert R. Shaw, Dallas.
Discussion—C. B. Young, Tyler.
Group Insurance for Medical and Surgical Service—C. C. Cody, Houston, President-Elect, State Medical Association.

Thirteenth District Society

March 28, 1946

(Reported by Joe R. Wise, Secretary)

Thirteenth District Medical Society had fifty-six registered for an all-day meeting in Eastland, March 28. The following program was given:

Welcome Address—A. W. Brazda, Ranger, President, Eastland-Callahan Medical Society.
The Diagnosis and Treatment of Urinary Frequency in the Female—James P. Bridges, Abilene.
Surgical Intervention in Cholecystic Disease—W. Burgess Sealy, Fort Worth.
Nephrosis—V. J. Donnelly, Bowie.
Diaphragmatic Hernia, Traumatic Origin, with Case Report—W. Harry Ledbetter, Wichita Falls.
Restoration of the Hand—J. R. Cochran, Fort Worth.
A General Consideration of the More Common Ano-Rectal Diseases—T. Wade Hedrick, Abilene.
Injuries of the Intestines—J. W. Tottenham, Jr., Fort Worth.

The membership agreed that programs should continue to be made up from papers presented by members of the society rather than by guests. Plans were made for a meeting in the fall, the date and place to be set later.

The society joined the Woman's Auxiliary for luncheon at the Connellee Hotel.

AUXILIARY NOTES

Officers of the Woman's Auxiliary to the State Medical Association of Texas: President, Mrs. C. B. Alexander, San Antonio; President-Elect, Mrs. George Turner, El Paso; First Vice-President, Mrs. S. M. Hill, Dallas; Second Vice-President, Mrs. L. W. O. Janssen, Corpus Christi; Third Vice-President, Mrs. Troy A. Shafer, Harlingen; Fourth Vice-President, Mrs. Mark H. Latimer, Houston; Treasurer, Mrs. F. R. Rugeley, Wharton; Recording Secretary, Mrs. Paul H. Power, Waco; Corresponding Secretary, Mrs. Wilbur Robertson, San Antonio; Publicity Secretary, Mrs. E. L. Howard, Fort Worth; Parliamentarian, Mrs. W. R. Klingensmith, Amarillo.

AUXILIARY NEWS

Bowie-Miller Counties Auxiliary met March 22 at the home of Mrs. Joe Tyson in Texarkana, with Mrs. J. T. Robison as cohostess. Mrs. William Hibbitts, president, presided.

Mrs. Roy Baskett reported on *Hygeia* subscriptions which the auxiliary had given to Texarkana schools and to the public library. Mrs. Robison reported on contacts made which might be helpful in defeating the Wagner-Murray-Dingell bill.

Mrs. Luline Fortune Willis was guest speaker, using as her subject "American Folk Music." Mrs. Willis traced the history of folks songs in America from the period of the puritans to the present time, singing several early folk songs, which she collects and studies as a hobby.

Guests were invited to the dining room for coffee, poured by Mrs. Hibbitts, and a dessert course served by Mrs. Robison and Mrs. Joe E. Tyson. Gladioli and candles decorated the table, and iris and other spring flowers were used throughout the rooms.

Bowie-Miller Counties Auxiliary is represented on the board of directors of the Texarkana chapter of the American Cancer Society, organized in April. Mrs. Ralph Cross and Mrs. H. E. Murry were named to the sixteen member board. Mrs. William Hibbitts was also present at the organizational meeting. The local chapter was organized to help control cancer through educational programs, cancer clinics, and other effective methods.

Brazoria County Auxiliary attended a dinner party with the medical Society, March 28, at the Civic Hall in Angleton. Following the dinner the auxiliary members assembled for their regular meeting .

The following officers were elected for the coming year: Mrs. William Greenwood, West Columbia, president; Mrs. G. J. Hayes, Alvin, vice-president, and reporter; and Mrs. William Holt, Angleton, secretary-treasurer.

Following the business meeting there was an open discussion on socialized medicine and the rapid penicillin treatment of syphilis.—Mrs. G. J. Hayes, Reporter.

Brazos-Robertson Counties Auxiliary met for dinner at the home of Dr. and Mrs. James Sidney Perry in Bryan on March 26. The Medical Society joined the auxiliary for dinner and held a separate business session afterward.

The auxiliary elected the following officers: Mesdames L. O. Wilkerson, Bryan, president; T. A. Searcy, Hearne, vice-president; W. M. Boguski, Hearne, treasurer; D. W. Andres, College Station, secretary; R. M. Searcy, Bryan, corresponding secretary; A. G. McGill, Jr., Bryan, reporter.

About thirty were present for dinner, which was served buffet style from a table centered with a spring flower arrangement flanked by burning white tapers in silver candelabra. Guests dined at small tables.

Dallas County Auxiliary honored new members January 2 at noon at the Dallas Country Club, with Mrs. Joseph H. McCracken, Jr., president, presiding. Mrs. Floyd S. Franklin, program chairman, presented Mrs. W. C. Edwards, Jr., of the staff of the Dallas Museum of Fine Arts, in a talk on children's art.

A doctors' day dinner was held in February at the Dallas Country Club. Following a duo piano concert of semi-popular numbers by Jeanne and Edward Deis, Miss Lois Sager, war correspondent of the Dallas *News*, told of medical conditions in Europe. Mrs. McCracken gave a summary of the auxiliary's social, philanthropic, educational, and legislative activities, including a report of a contribution of $250 to Southwestern Medical Foundation. Program cochairmen were Mesdames Dayton G. McBride and Cecil O. Patterson. Hostesses were the executive board, including Mrs. McCracken, president; Mrs. J. Forest Buchanan, president-elect; Mrs. McBride, first vice-president; Mrs. Sidney S. Baird, second vice-president; Mrs. J. Dennis O'Brien, third vice-president; Mrs. Guy A. Tittle, recording secretary; Mrs. T. W. Bywaters, corresponding secretary; Mrs. Harry B. Sowers, treasurer; Mrs. Hall Shannon, parliamentarian; Mrs. J. R. Maxfield, Jr., publicity; and Mrs. U. P. Hackney, historian.

The program for the March 6 meeting at the Dallas Country Club was presented by Mrs. John V.

Goode, who introduced an astrologist in a talk entitled "Madam Caesall Looks at the Stars." New officers were elected, to be installed in May. They include Mesdames J. Forest Buchanan, president; John M. Pace, president-elect; Ridings Lee, first vice-president; W. E. Carswell, second vice-president; Carl Carter, third vice-president; John Bourland, recording secretary; Lewis C. Sams, corresponding secretary; Alvin Baldwin, treasurer; Charles Martin, parliamentarian; Ben Harrison, publicity; and U. P. Hackney, historian.

Guest day was observed April 3, at which time Mrs. Roscoe Bates reviewed a book entitled "Ancestor's Brocade," a biography of Emily Dickinson. Mrs. McCracken introduced a group of doctors' wives from Fort Worth. Mrs. McCracken and Mrs. Buchanan were elected as delegates to the State Auxiliary meeting in Galveston in May, with Mrs. Guy Jones and Mrs. John Pace as alternates.

Dr. Frank Selecman, member of the Public Relations Committee of the State Medical Association, spoke on medical legislation at the May 1 meeting, with Mrs. S. F. Harrington as program chairman. Officers elected in March were installed. Past presidents of the auxiliary were hostesses.—Mrs. J. R. Maxfield, Jr., Publicity Chairman.

El Paso County Auxiliary heard Dr. I. M. Epstein at a buffet luncheon in the Hilton Hotel in March. His subject was "Recent Developments in Medical Science." Yellow jonquils and pink sweet peas in a blue epergne decorated the buffet table, and floating pansies centered the small tables.

Falls County Auxiliary met in March with Mrs. J. D. Collier. The auxiliary is sponsoring a health project in the public schools of Marlin, by which funds donated by the auxiliary are used so that children suspected of having tuberculosis may be given skin tests and, if the tests are positive, receive treatment.

Falls County Auxiliary on April 11 sponsored the showing of a motion picture on malaria at the high school gymnasium, which the public was invited to attend without charge.

Galveston County Auxiliary was entertained at a tea given by Mrs. Charles T. Stone in her home on March 15. During the business meeting the following new officers were elected: Mesdames John Otto, Galveston, president; T. M. Frank, Texas City, vice-president; John Thiel, Galveston, secretary (re-elected); Hamilton Ford, Galveston, corresponding secretary; and Hughes Gilliam, Galveston, treasurer.

"The Surgeon in the Romantic Story of Texas" was the subject of an illustrated lecture given by Dr. A. O. Singleton, professor of surgery at the University of Texas School of Medicine. He briefly traced the history of the surgeon in Texas from Cabeza de Vaca in 1528, through the days of Ashbel Smith and Anson Jones, down to the time of Drs. James E. Thompson, Edward Randall, and Seth Morris, the only living member of the original faculty of the University of Texas School of Medicine.

Mrs. J. L. Jinkins, chairman of the game-day party held February 15, reported that $571.17 was given to the loan fund for medical students. Local committee chairmen were announced and plans were made for the State Auxiliary meeting to be held in Galveston May 6-9.

The tea table was centered with an arrangement of daffodils and blue iris, flanked by yellow tapers. Presiding at the tea and coffee services were Mrs. W. S. Carter, Greenwich, Conn., wife of the late Dr. Carter, who was twice dean of the University of Texas School of Medicine; Mrs. M. L. Graves, Houston; Mrs. Edward Randall, Sr., and Mrs. A. O. Singleton. Assisting Mrs. Stone as hostesses were Mesdames C. M. Nave, Meyer Bodansky, Chauncey D. Leake, H. Reid Robinson, and Willard R. Cooke.

Grayson County Auxiliary elected officers at its meeting in March at Hotel Denison, in Denison. Mrs. Arthur Gleckler, Sherman, was elected president; Mrs. Doak Blassingame, Denison, vice-president; Mrs. Frank Sporer, Van Alstyne, second vice-president; and Mrs. C. D. Strother, Sherman, secretary-treasurer. In the absence of Mrs. W. A. Lee, Mrs. J. E. Meador presided over the session, at which twenty-two members were present.

Dr. A. L. Ridings, Sherman, spoke on "Progress of Scientific Medicine." Four new members, Mesdames Charles Truett, James E. McFarling, M. Cohen, all of Denison, and John Hardy, Sherman, were introduced.

Preceding the business session and program, luncheon was served. The table was centered with a crystal bowl containing mixed yellow spring flowers, and shamrocks were used as plate favors.

Harris County Auxiliary sponsored a health institute at the Sears Roebuck Auditorium, Houston, on Friday morning, April 5, to which the public was invited.

Speakers included the following members of the Baylor University College of Medicine faculty; Drs. Don Chapman, department of internal medicine, who spoke on heart disease; W. M. Fisher, department of public health and preventive medicine, "Domestic Help as Disease Carriers"; George Salmon, department of pediatrics, "Congenital Anomalies"; Harbert Davenport, department of pathology, "A Pathologist Looks at Cancer."—Mrs. Granville Q. Adams, Press Secretary.

Kerr-Kendall-Gillespie-Bandera Counties Auxiliary met April 5 at the home of Mrs. L. L. Keyser at Fredericksburg, with Mrs. L. A. Feller and Mrs. H. G. Pfeiffer as cohostesses.

Officers for the coming year were elected unanimously from the recommendations presented by the nominating committee. They include president, Mrs. L. L. Keyser, Fredericksburg; first vice-presidents, Mrs. D. R. Knapp, Kerrville, and Mrs. C. C. Jones, Comfort; second vice-presidents, Mrs. C. F. Culver, Kerrville, and Mrs. L. A. Feller, Fredericksburg; third vice-president, Mrs. Duane Packard, Kerrville; recording secretary, Mrs. David McCullough, Kerrville; treasurer, Mrs. A. P. Allison, Kerrville; parliamentarian, Mrs. C. C. Jones, Comfort; and historian, Mrs. C. B. Matthews, Kerrville.

The final reports on the annual Tuberculosis Christmas Seal sale which the auxiliary sponsors were given. Since the auxiliary started sponsoring this project, there has been a yearly increase in the amount collected. Total sales for this year amounted to $1,515.19 as compared with $1,504 in 1944 and $1,409 in 1943. The cash balance in the fund is now $2,143.81. In addition, bonds having an actual value of $1,572.50 and maturity value of $2,125 are in the fund. The auxiliary took in $54.30 at booths and receipts from bangle sales amounted to $82.87 this year.

Under the administration of the County Tuberculosis Society, the auxiliary has also helped in giving patch tests to school children. Including the patch tests which were given last year to school children in Kerr County, a total of 670 children have been tested and examined. Patch tests will be given at the elementary schools in Kerrville during April, completing this year's work.

Mrs. H. H. Gallatin was appointed alternate for Mrs. W. E. Gregg, president, to represent the auxiliary at the meeting of the State Auxiliary in Galveston in May, and Mrs. Sam Thompson was appointed official delegate.

Mrs. Gallatin told many interesting things about the organization of the Four-Counties Woman's Auxiliary on July 1, 1931. Mrs. Gallatin was the first president of the auxiliary, and many of the other charter members were present at the meeting. The information she gave is to be included in an article being written by Mrs. L. A. Feller for the centennial edition of a Fredericksburg newspaper.

After the meeting was adjourned, Mrs. Gregg presided at the tea table. She was assisted in serving by Mrs. Gallatin.—Mrs. David McCullough, Recording Secretary.

Eleventh District Auxiliary met March 29 in Jacksonville, first joining the Medical Society for dinner at the Liberty Hotel and then adjourning to the home of Mrs. R. T. Travis for a business session, at which twenty-two were present.

Mrs. L. B. Windham, Tyler, president of the auxiliary, conducted an election in which Mrs. G. M. Hilliard, Jacksonville, was named president. Other officers elected include Mesdames J. L. Dean, Crockett, first vice-president; C. B. Young, Tyler, second vice-president; A. L. Kuykendall, Rusk, third vice-president; R. H. Hodge, Athens, recording secretary; J. M. Travis, Jacksonville, corresponding secretary and treasurer; T. M. Jarmon, Tyler, parliamentarian; and T. A. Stevens, Jacksonville, reporter.

Thirteenth District Auxiliary met in Eastland on March 28. Mrs. A. W. Brazda, Ranger, president, welcomed the members. Following a luncheon at the Connellee Hotel with the Medical Society, the auxiliary heard Mrs. John Thurman review a book.

BOOK NOTES

[1]**Pediatric X-Ray Diagnosis.** A Textbook for Students and Practitioners of Pediatrics, Surgery and Radiology. By John Caffey, A. B., M. D. Associate Professor of Pediatrics, College of Physicians and Surgeons, Columbia University; Associate Pediatrician and Roentgenologist, Babies Hospital and Vanderbilt Clinic, New York City. Cloth, 818 pages. Price, $12.50. Chicago, Year Book Publishers, Inc., 1945.

The publishers are to be commended for adding to their growing list of excellent monographs this timely and thoroughly useful book, said by the author to have stemmed from semimonthly roentgen conferences at the Babies Hospital in New York over the last twenty years.

As the title indicates, discussion is limited to diagnosis and interpretation of x-ray studies in infants and children. The 818 pages are divided into sections which deal exhaustively with the various anatomical divisions of the body. An excellent feature is the inclusion at the beginning of each section of an illustrated description of the pertinent regional anatomy. Throughout the book, roentgen interpretation is closely related to anatomical considerations, and the normal variations are emphasized.

Perhaps the best of the several appealing characteristics is the striking excellence with which the many roentgenograms and drawings are chosen and reproduced. The reviewer found not a single figure which failed to illustrate well the intended features. As an x-ray atlas alone the book would have much value.

Little adverse criticism can be offered. Peptic ulcer, although uncommon in infants and children, would seem to warrant more attention than a single paragraph without illustration. Quite brief consideration is given also to steatorrhea, celiac disease, and related conditions.

The printing and format are a pleasing improvement over many wartime publications.

VENEREAL DISEASE ABSTRACTS*

Preliminary Report Evaluating the Worth of Obtaining Names of Suspected Contacts During a Regular Contact Interview. W. D. Hazelhurst, C. P. Stevick, and Harold A. Kahn. Journal of Venereal Disease Information, Washington, 27:65-68 (March) 1946.

In a preliminary tabulation of 599 persons reported by infected patients, not as direct contacts, but as "suspected contacts," the authors found that the percentage of these suspected contacts brought to treatment was 9.0 in comparison to 9.9 direct contacts named. In an addendum, the authors emphasize that future experience with this casefinding method has proven less useful than was indicated by earlier practice. The addendum states that the method was largely discontinued, and that it is not recommended for general use in health departments and rapid treatment centers.

Summarizing the study, the authors state that a tabulation was made showing the results of investigation of 599 suspected contacts reported during March-June, 1945, by clinic patients as: (a) promiscuous, although the patient denied any sexual exposure to the person named; (b) exposed to a direct contact already named by the patient, but not directly exposed to the informant himself; (c) participants in hotel parties, brothel escapades, and so forth, of which the patient was a member, although direct exposure is denied.

A large proportion of the new infections discovered by this means of interviewing were early cases. Of 24 such syphilis cases brought to treatment, 11 were primary or secondary, 7 were latent, and 6 were not specified.

There appears to be a strong relationship between the disease of the informant and the disease of the suspected contact named. Of 62 suspected contacts found infected, only 9 were infected with a disease not diagnosed in the informant.

Further careful studies of this method are suggested so that its efficiency and value as a casefinding instrument can be accurately determined.

Oral and Parenteral Use of Aluminum Penicillin Mixtures in the Treatment of Gonorrhea. S. W. Bohls, E. B. M. Cook, and R. T. Potter. Journal of Venereal Disease Information, Washington, 27:69-74, (March) 1946.

The authors found that a total dose of 400,000 units of penicillin in an oral tablet containing aluminum potassium sulfate and sodium benzoate resulted in a "cure rate" of 97.2 per cent in a series of 36 female gonorrhea patients.

A total of 74 patients with gonorrhea were treated by the oral penicillin tablets (each tablet containing 25,000 units of penicillin) in four different schemes.

In the first scheme of treatment, 10 patients with culturally positive gonorrhea were treated with a single oral dose of 100,000 units of aluminum penicillin with sodium benzoate. Cultures were made 48 hours later, and 4 were found to be positive and 6 negative. The penicillin blood level of this group at 24 hours averaged 0.023 units per milliliter of blood serum.

In a group of 15 patients, a dose of 200,000 units maintained a penicillin blood level of an average of 0.078 units per milliliter of blood serum for over 24 hours. Cultures made from these patients 48 hours after the medication was given showed that only 1 was positive for gonorrhea.

In another series of 49 patients, 13 patients were given 100,000 units of penicillin in this tablet form at 7 to 8 a. m. and at 3 to 4 p. m. on two successive days. Follow-up cultures as tests of cure were taken at 48, 72, 96, and 120 hours. There were 3 failures among this group giving a failure rate of 23.1 per cent. Penicillin blood levels were not obtained on any of these 49 patients.

[1]Reviewed by John S. Bagwell, M. D., Dallas, Texas.

*Abstracts of articles appearing in *The Journal of Venereal Disease Information* (formerly *Venereal Disease Information*) prepared by the Venereal Disease Division, U. S. Public Health Service.

The remaining 36 patients of this series were given a total dosage of 400,000 units, with 200,000 units being given at approximately 7 to 8 a. m., followed by an additional 200,000 units 7 to 8 hours later. Each of the 36 patients had cultures taken as tests of cure at 48, 72, 96, and 120 hours. There was only 1 failure among the 36, giving a failure rate of only 2.8 per cent.

No untoward signs of symptoms were experienced with this type of penicillin therapy. The authors point out that since this is a preliminary report, the optimum time-dosage schedule of this type of oral penicillin therapy in the treatment of gonorrhea has not yet been ascertained.

A review of penicillin therapy for gonorrhea is given; the use of aluminum penicillin preparations by injection with and without the addition of oral benzoic acid in the treatment of gonorrhea is discussed. The aluminum causes relayed absorption and the benzoic acid inhibits renal excretion of the penicillin.

DEATHS*

Dr. Joseph Reuss Frobese, Austin, Texas, died in a hospital there of carcinoma of the liver on February 8, 1946.

Born in Cuero, July 13, 1884, Dr. Frobese was the son of William and Alfreda (Reuss) Frobese. His father was president of H. Runge and Company at Cuero, the oldest private banking firm in Texas. Dr. Frobese attended the Cuero public schools and received a bachelor of science degree from the University of Texas. He then was graduated in medicine from the University of Texas School of Medicine Galveston, in 1910, remaining in Galveston to serve an internship at John Sealy Hospital. He began practice in Cuero, where he was health officer of DeWitt County, but moved to San Antonio in 1925, and to Austin in 1931, practicing in the latter city until shortly before his death. He specialized in urology and proctology, and was urological consultant for the International and Great Northern Railway. He was an active member of the staffs of Brackenridge and Seton Hospitals in Austin.

DR. JOSEPH R. FROBESE

Throughout his professional life Dr. Frobese was a member of the State Medical Association and American Medical Association, first through the DeWitt County Medical Society, then through Bexar County Medical Society, and more recently through Travis County Medical Society. He was also a member of the Southern Medical Association and of the American Urological Association. He was a member of Delta Tau Delta fraternity at the University of Texas in Austin and of Alpha Kappa Kappa fraternity at the School of Medicine in Galveston. He was a member of the Blue Lodge and Royal Arch Masons at Cuero, the Commandery at Yoakum, the Consistory and Shrine at San Antonio, the Austin Ben Hur Temple, Austin Chamber of Commerce, and the Baptist Church.

In 1912 Dr. Frobese married Miss Pearl Cade, of San Antonio, who died in 1913. In 1917 in Hallettsville he married Miss Mary Valerie Mair, of Houston, who survives. He is also survived by two sons, Joseph Cade Frobese, Brenham, and Dr. Alfred Searcy Frobese, Austin; one daughter, Miss Mary Valerie Frobese, Austin; three sisters, Mrs. H. E. Leonardt, Miss Alma Frobese, and Miss Anne Frobese, Cuero; and two brothers, Alfred Frobese, Yoakum, and Charles Frobese, Westoff.

Dr. William Cook Lackey, Fort Worth, Texas, died of heart disease in a local hospital April 5, 1946.

The son of Charles and Mary Elizabeth Lackey, Dr. Lackey was born December 8, 1875, in Smiths Grove, Ky., but moved to Texas as a boy. He attended the schools in Sherwood, Texas, and studied at Fort Worth University, where he was graduated with the highest grades made there to that date, before taking his medical degree at Memphis Hospital Medical College, Memphis, Tenn., in 1903. He later did postgraduate work in New York. Dr. Lackey returned to Fort Worth to practice and had been active in his profession until his death. He was on the staffs of Harris Memorial Methodist, All Saints Episcopal, and St. Joseph's Hospitals.

DR. W. C. LACKEY

Dr. Lackey was a charter member of the Tarrant County Medical Society after its reorganization in 1903, and had been a member continuously throughout his professional life of the county society, State Medical Association, and American Medical Association. He was a deacon of Broadway Baptist Church, Fort Worth; a trustee of Buckner Orphans' home, Dallas; and had furnished funds to help build and maintain several missionary churches in Korea. He was a Royal Arch Mason, a member of the Shrine, Knights Templar, Worth Commandery, and the Kiwanis Club.

Surviving Dr. Lackey are his wife, the former Miss Elizabeth Kistler, whom he married in Fort Worth on August 19, 1902; two brothers, J. E. Lackey, Mertzon, and G. S. Lackey, Fort Worth; and five sisters, Mrs. Madie Blair, Mrs. Savannah Bowles, and Mrs. C. J. McDonough, all of Fort Worth, and Mrs. Katherine Ross, Houston, and Mrs. S. C. Frost, Dallas.

*An obituary ordinarily will not be published more than four months after date of death. Coöperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

CLAUDE C. CODY, JR., A. M., M. D., D. Sc. (hon.), F. A. C. S.
Eighty-first President, State Medical Association of Texas
HOUSTON, TEXAS

Texas State Journal of Medicine

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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION AND PUBLIC HEALTH IN TEXAS

Dr. Claude Carr Cody, Jr., of Houston, became the Eighty-first President of the State Medical Association of Texas at the concluding meeting of the Association in Galveston, May 9, 1946, after having held the office of President-Elect of the Association for the two administration years of 1944-1945 and 1945-1946. The occasion for the one year delay in the normal succession to the office of President was World War II, which prevented the holding of an annual session in 1945.

Dr. Cody was born September 9, 1884, at Georgetown, Texas, the son of Claude Carr and Martha R. (Hughes) Cody. His father was a distinguished Texas educator, having served Southwestern University at Georgetown as Professor of Mathematics from 1879 to 1915, as Dean of the Faculty from 1905 to 1915, and as Dean Emeritus thereafter until his death in 1923. After completing his preliminary education in the public schools of Georgetown Dr. Cody attended Southwestern University, from which he received the bachelor of arts degree in 1904, and master of arts degree in 1905. He then attended Johns Hopkins University, Baltimore, being graduated from that institution with the degree of doctor of medicine in 1910. After graduation he served an internship and as house surgeon, First Surgical (Columbia University) Division, Bellevue Hospital, New York City, from 1910 to 1912.

Dr. Cody was engaged in the general practice of medicine and surgery at Houston, Texas, from April 1, 1913, to July 1, 1917. After the entry of the United States into World War I, he was selected by Harris County Medical Society to organize a Red Cross Unit in April, 1917. He was commissioned a first lieutenant in the Medical Reserve Corps, U. S. Army, on June 2, 1917, and was called to active duty on July 16. On August 8 he was ordered to mobilize an ambulance company, following which he served as commander of Ambulance Company 357 at Camp Travis, Texas. He later served in the Surgeon General's office, Washington, D. C.; as surgeon with Base Hospital 116, Bazoilles-sur-Meuze, France; with Mobile Hospital 9 in Flanders; Camp Hospital 119, Laval, Army Embarkation Area; and at General Hospital 41, Fox Hills, Staten Island, N. Y. He received his honorable discharge as a major in the Medical Corps, A. E. F., U. S. Army, on August 20, 1919, and returned to general practice in Houston on September 1.

Electing the specialty of otolaryngology, Dr. Cody attended the Graduate Medical School of the University of Pennsylvania 1920-1921, following which he returned to Houston for practice in this field. He received further training in his specialty in Vienna, in 1931.

Dr. Cody has held the following hospital and other appointments in Houston: Southern Pacific Hospital, 1913-1917; attending otolaryngologist, Baptist Hospital, 1922-1926; Jefferson Davis Hospital, 1922-1929; Methodist Hospital, 1924-1926; Houston Eye, Ear and Throat Hospital, 1924. He has been consulting otolaryngologist at the Methodist Hospital since 1926, and Professor and Head of the Department of Otolaryngology of Baylor University College of Medicine since the location of that school in Houston in 1943.

Dr. Cody's interest and leadership in med-

icine in Texas is attested to by the numerous offices of honor and trust he has held in his county society, the State Medical Association, and in national organizations. He served Harris County Medical Society as president in 1923, and as delegate to the State Medical Association continuously from 1924 to 1932. He served as a member of the Board of Trustees of the Houston Academy of Medicine from 1919 to 1939 and from 1943 to the present. He was president of the Academy in 1929; chairman of its Eye, Ear, Nose, and Throat Section in 1930; and a member of its library committee 1919-1941 and 1942-. He served as president of the Texas Ophthalmological and Otolaryngological Society in 1934.

Dr. Cody has rendered outstanding service to the State Medical Association during his professional career. Reference has already been made to his long years of service in the House of Delegates where he made notable contributions on important committees. His sincerity, devotion to the ideals of medicine, and fine analytical mind, have always commanded the respect and earned for him the confidence of his fellows. His greatest contribution to Texas medicine perhaps has been in the field of medical economics. He served as a member of the Council on Medical Economics from 1936 until his election to the office of President-Elect in 1944, being chairman of the Council from 1939 to 1944. He was untiring in the work of the Council, and during this period he traveled widely and represented the Association in its economic relations with governmental and other agencies with rare talent and discrimination. The annual reports of the Council to the House of Delegates during his tenure of office as chairman are monumental records of principles that have been valuable guides to medicine during the social changes of the present, and attracted national attention.

Dr. Cody served as chairman of the Eye, Ear, Nose, and Throat Section of the State Medical Association in 1938, and as chairman of the Section on Laryngology, Otology, and Rhinology of the American Medical Association 1942-1944. He is a diplomate of the American Board of Otolaryngology; and a fellow of the American Academy of Ophthalmology and Otolaryngology, American College of Surgeons, American Laryngological, Rhinological, and Otological Society, American Laryngological Association, and American Otological Society.

He has made numerous valuable contributions to medical literature in his specialty, which have received publication in all of the outstanding national medical journals as well as in the TEXAS STATE JOURNAL OF MEDICINE.

Dr. Cody has served as chairman of the Board of Trustees of Southwestern University, Georgetown, Texas, since 1934. The honorary degree of doctor of science was conferred upon him by that institution in 1940. He was elected a director of the Houston Chamber of Commerce in 1946. He is a steward of St. Paul's Methodist Church, and a member of River Oaks Country Club in Houston.

Dr. Cody was married to Miss Florra Root, daughter of James L. and South (Easley) Root, on August 12, 1917, at Taylor, Texas. There are no children.

This brief account of the highlights of Dr. Cody's life points to the two outstanding attributes which he possesses and which brought to him the highest honor Texas medicine can bestow, as well as the greatest responsibility for its future it can place in the hands of a trusted servant. These attributes are his insatiable zeal for scientific advancement not only personally but for his fellows, and his keen appreciation and interest in medical economics. As a member of the library committee of the Houston Academy of Medicine he has had a large part in the development of an outstanding library for that institution. It is anticipated that he will bring notable leadership to the scientific advancement of Texas medicine during his tenure of office. His peculiar qualities and extraordinary understanding of medical economic problems assure Texas medicine of the finest type of leadership in that regard at a time when it is most needed.

We bespeak for Dr. Cody the warm support of the membership of the State Medical Association during his administration.

The Galveston Annual Session, the first full-dress meeting the State Medical Association has held in four years, was the success, pleasure, and delight we had all anticipated that it would be. The only fly in the ointment was lack of housing, or, perhaps more accurately stated, the general feeling that there would be a shortage of hotel accommodations. At that, quite probably Galveston was in position to provide more rooms and more hotel accommodations than any other city in the state. And as a sort of aside, we may say that while doctors are prepared to undergo extreme hardships in connection with their professional practice, when they go visiting they want to go visiting, and in style. One hotel manager told us some years ago that practically every doctor who wrote in for accommodations, wanted double rooms with southern exposure. There are not, of course, that many of that sort of rooms, even in Galveston.

In this connection, we may say here that

when we were making inquiries as to which of our cities in the higher population bracket could take care of one of our regular meetings, we were told, without exception, that it simply could not be done. Galveston advised that she was ready, having invited the Association to meet there when not so many complications were involved, and would see to it that we were properly and adequately cared for. That is exactly what happened, in spite of an occasional criticism which may be heard about housing. A member of the local Committee on Hotels stated positively that if any visitor in Galveston went without a place to sleep during the annual session, it was his own fault. There were beds enough for all.

The last time the Association met in Galveston, in 1938, the total registration was 2,010. Of these, 1,185 were members. There were 537 women, and the balance was made up of visitors, guests, medical students, and technical exhibitors.

The total registration at the recently concluded meeting was 1,799, of which 1,024 were members. There were 440 women. The large number of visitors, 217, really included many who should be counted as members, Medical Officers who were on terminal leave, or about to be separated from the Service, and who expected to get back into the regular membership ranks without delay. There were 21 guests, and 97 exhibitors. The Senior Class of the Medical Branch of the University of Texas attended in large numbers, as did many of the Senior Class from Baylor University College of Medicine at Houston.

The largest attendance the Association has ever had at one of its annual sessions was at Dallas, in 1940, at which time 2,617 were registered. This number was broken down as follows: members, 1,562; women, 644; visitors, 86; medical students, 173, and exhibitors, 154.

In figuring the attendance on any one of our meetings, it is well to remember that practically all of the local medical profession register, which may mean an advantage of several hundred in the larger over the smaller cities.

While it is quite probable that the average expectation was that those who attended the Galveston meeting would be more interested in playing than anything else, including the attractions of the beach, the fact remains that the greatest interest manifested by visitors was in the scientific program. The Sections were well attended and the attendance on the General Meetings was unusually good. The Clinical Luncheons were fairly well attended on the second day of the meeting, but the Combined Sections Luncheon on the last day was poorly attended. The usual thing happened. The brethren got in a hurry to get home, which meant an early start by those who came to the meeting in their cars, as it is a long way from Galveston to many of their homes.

Section Officers had done well by the scientific program, and the distinguished guests were in every way acceptable. They were mainly young men, and they did well in presenting their subjects. All of the addresses were, without exception, interesting and informative. This was the second scientific program prepared by many of the Section Officers. They should be given a hand.

The Memorial Services, in keeping with tradition, were well attended, and the ceremony was beautiful. A list of 270 physicians who died during the years 1944-1945 and 1945-1946 was read. Of these, 138 were members at the time of death, and 132 were nonmembers.

The Woman's Auxiliary held its own meetings, as per usual, but joined our group in the Opening Meeting and in the Memorial Services. At the Opening Meeting, the Wartime Presidents of the Woman's Auxiliary were presented. It was the intention to present the Wartime Presidents of the State Association, but only one of these is living, and he was not able to attend the meeting. These presentations were to compensate for failure to hold general meetings at any time during the war.

The decision to hold an all-out annual session this year came rather precipitately, considering the amount of detail that must be worked out precedent to such a meeting. Even so, the only regular feature of the annual session which suffered was the scientific exhibits, usually a very interesting and important part of our meetings. There simply was not time for that sort of thing. Therefore, we feel particularly grateful to the several exhibitors who took the time and went to the expense and trouble in presenting what proved to be very interesting and attractive exhibits.

The social features of the meeting were the delight they always are and always will be in Galveston, in spite of our effort to curtail entertainment. Our hosts started in with the idea of entertaining to the extent possible without regimentation, but eventually there was a climax, one that will be remembered with pleasure by the many who attended. The President's Reception and Ball was held in the Ballroom of the Hotel Galvez. Nearly everybody was there, the music was good, and the dancing delightful.

The usual related organizations held their

meetings on Monday preceding the opening of our meetings, and they were all well attended.

We feel that, under the circumstances, we should extend special thanks to the Arrangements Committee, headed by Dr. Dick P. Wall, and take our hats off to the Hotels Committee, headed by Dr. E. S. McLarty.

Dr. B. E. Pickett, Sr., of Carrizo Springs, was elected President-Elect.

The next annual session will be held in Dallas, at a date to be fixed by the Executive Council of the Association.

The House of Delegates at Galveston had a man-sized job cut out for it, and it "done noble," as witness the voluminous and intricate Transactions, published in this number of the JOURNAL. Officers, Councils, and Committees had to account for an administration of two years duration, which was no small task. It is difficult enough to present an informative and (hopefully) interesting account of what is done in one year. To cover a period of two years, with no intervening action by the House of Delegates, more than doubles the difficulties.

Attendance on the meetings of the House of Delegates was unusually high. A total of 125 delegates were seated, of which 28 were ex-officio and 97 were elected by county medical societies. The attendance on the House of Delegates in 1944, the nearest opportunity for comparison, was 113, of which 27 were ex-officio and 86 were delegates from county medical societies. The year before that, the total attendance was 110, of which 29 were ex-officio and 81 delegates from county medical societies. It would seem, therefore, that the ratio of the two groups remains fairly constant, and rather definitely in balance.

Legislation.—Perhaps the most immediately important problem and the one of greatest interest at the moment dealt with by the House of Delegates was that of legislation. The Legislative Committee presented a report which the Reference Committee having the matter in charge stated was one of the most important reports ever presented to the State Medical Association. The phase of the report which required immediate attention was that pertaining to medical licensure. The Legislative Committee assumed that the mandate of the House of Delegates that a basic science bill and a revised Medical Practice Act be introduced in the Legislature and pushed to favorable conclusion would now prevail, following a lapse of the wartime interdiction against controversial legislation of the sort. A resolution was introduced in the House of Delegates reciting the fact that the legislative program of the State Medical Association includes a basic science law, and that our General Attorney had prepared a measure of the sort, which had three times been approved unanimously by the Executive Council and twice by the House of Delegates, and which was introduced in the 48th Session of the Texas State Legislature. The resolution directed the present Legislative Committee to "introduce the same medical legislation in the next Texas State Legislature, at the earliest possible date after its convening, and work for the passage of the legislation." Both the report of the Legislative Committee, and this resolution were approved by the House of Delegates. An effort was made to change the policy in some particulars, but it did not prevail. It would seem, therefore, that the Legislative Committee has a mandate to seek the passage of a basic science bill and a Medical Practice Act modified accordingly.

The recommendation was made that the basic science bill carry a requirement that at least two members of the basic science board be physicians with the degree of "M. D." This recommendation failed of adoption.

It is hoped by those in charge of the legislative activities of the State Medical Association that at least this part of the Transactions be read by every member of the Association, so that there may be no doubt about the policy of the medical profession of Texas as relates to the important and far-reaching problem of medical licensure. There should be a solid legislative front at Austin, not alone in these matters, but in every other legislative activity of the State Medical Association. If this be politics, let the opposition make the best of it. We have not yet found any way to protect our people against ignorance and incompetence in the sick-room except through the use of political expedients. And we may say in passing, that the politics of organized medicine has been child's play compared with that practiced by other groups seeking legislation.

Our Public Relations Campaign will continue, under the direction of the Committee on Public Relations, which committee remains a committee of the Board of Trustees. There was some question in the discussion of the very excellent report of this committee, and the very fine work it had undoubtedly done, as to whether its objectives had been fully attained, or attained to the degree that should have been the case, particularly in the matter of educating the public on the very confusing problems involved in our legislative activities on both the state and national levels. However, the Reference Committee recommended that the work continue, and that, if necessary, its financial support be materially increased. It will be understood in this connection, that the activities of this committee were in direct support of policies of the Legislative Committee. Indeed, it works, and is presumed to work only in coöperation with the officers, councils, and committees of the Association having to do with carrying out policies as set by the House of Delegates. It is not an overall committee, and has no intention of assuming the prerogatives of any committee. It certainly does not make policy, except such policy as pertains directly to the functioning of the committee, and that is supervised by the Board of Trustees. This is one committee that must be encouraged and supported if it is to do its job and do it effectively and well.

Medical Economics continues to be spotlighted. The Council on Medical Economics announced in its annual report the six principles adopted by the Council as guide-posts for insurance companies, associations, and societies engaged in the prepayment plan of the distribution of medical service, profit or nonprofit. These six principles will be promulgated widely and emphasized considerably in the near future. They will be extremely helpful in evaluating prepayment health insurance, of whatever sort or by whatever name it is called. Together, these principles merely require that all such companies be solvent; that they be as nearly nonprofit as is consistent with sound business principles; that they should insure free choice of physicians and not permit any violations of medical ethics in connection with the service for which

they pay; that they make it clear that the money allowed under their respective policies is merely payment made on the services of the doctor; that no hospital be paid for medical service, in view of the fact that a hospital cannot render medical service, which is the exclusive function of the doctor; and that all efforts to insure medical service be understood to be tentative and that changes in plans must be expected. The Council on Medical Economics expects to set up machinery for the proper evaluation of all such sickness insurance policies and for the study of all phases of medical economics.

In the midst of these considerations has fallen the problem of the so-called coöperative hospitals, in many of which it is believed the principles of medical ethics are being violated, and conditions set up which make it impossible for medical staffs to render the sort of service they should render. The fact seems to be overlooked that a hospital cannot and should not, in the protection of the public health, undertake to practice medicine. They can only provide the ways and means of doing that. The Council on Medical Economics will of necessity consider this problem, and the Executive Council has directed the Committee on Public Relations to use its good offices and best efforts in persuading the coöperative hospitals that their objectives can be obtained as certainly and as economically in coöperation with the ethical medical profession as they can through the employment of physicians for service in violation of medical ethics. In this connection, the Chairman of the Committee on Legislation insisted in discussing the problem of legislation and related matters, that the repeated creation by the State Medical Association of committees to take over functions of councils and committees already and long since established, is not sound policy. The activities of the Public Relations Committee in connection with these matters appears to be quite consistent with the purpose of its creation. No doubt it can and will work in close coöperation with the Council on Medical Economics in dealing with the problem of coöperative hospitals and medical service.

The Procurement and Assignment Committee sang its swan song at the meeting of the House of Delegates. The Committee under such designation has ceased to exist, after a service of the greatest importance to our national defense and the medical profession of Texas and the nation. The House of Delegates thought the committee had done its job well, and said so. The records of the committee will remain in the office of the State Medical Association, and the only remaining problem of the Procurement and Assignment Service, the relocation of doctors, has been taken over by the State Medical Association. Whether the committee will be continued in its former status of Committee on Military Affairs, remains to be seen. The American Medical Association has set up a committee to deal with military problems, and it may be that this committee will be revived and will work in conjunction with the national committee.

The Committee on Cancer submitted a complete and detailed plan for cancer work in Texas, including research, education of both the medical profession and the lay public, and service to cancer patients, both professional and nonprofessional. There was a disposition on the part of some who discussed the matter in the House of Delegates to criticize the use of laymen in much of the work involved in this extensive enterprise. However, the plan proposed by our Cancer Committee so clearly placed the whole problem in the hands of the medical profession, even the organized medical profession, that there was unanimous endorsement of the plan by the House of Delegates.

A Pediatric Survey was proposed by a committee of pediatricians in the state, a part of a national movement being conducted by the American Academy of Pediatrics and the American Pediatric Society. There was criticism of the plan because of the accepted coöperation of the pediatric groups with the Children's Bureau of the Federal Government, and the United States Public Health Service. It was pointed out that the amount of coöperation of these two federal agencies was strictly limited to office work, and that the whole survey is under the direction of practicing pediatricians. The matter was left open, pending action of the Texas Pediatric Society.

Cooperation with the Texas Hospital Association was assured by a very excellent address delivered to the House of Delegates by Mr. William O. Bohman, Superintendent of John Sealy Hospital, Galveston, who was accredited to us as a Fraternal Delegate. Mr. Bohman gave a brief running account of the workings of his organization, and suggested a number of points of mutual interest where coöperation between the two groups could and should be immediately forthcoming. He advised that the Osteopathic Association had requested his organization to appoint a committee to meet with a committee of the osteopaths in the discussion of a number of problems which the osteopathic group believed may be of mutual interest, and therefore to be helpfully discussed. The Hospital Association advised that it would comply with the request of the osteopaths if the State Medical Association would set up a committee to join in any such conference. The House of Delegates decided that nothing was to be gained from such a conference, hence, for its part, denied the request. It might be said in this connection, perhaps in parenthesis, that had a real coöperative plan between the Hospital Association and the State Medical Association been in operation at the time of the fiasco in the so-called osteopathic hospital bill (H. B. 314), there would have been no trouble whatsoever. The legislative working agreement between the two organizations on that measure was assumed because of the use of mutual legislative tactics in two previous sessions of the Legislature, on practically the same measure. The trouble was there was no liaison between the Hospital and the Medical Associations.

Pathologic Laboratories came in for brief attention. The importance of the question is likely to be overlooked. It was recommended that the Medical Practice Act of the state be so amended as to require all such laboratories to operate under the supervision of licensed physicians. It is hoped that can and will be done.

Anesthesiology a Medical Specialty.—A resolution was adopted recommending to "Texas Hospitals, the Blue Cross Plan, and any or all insurance plans approved by the State Medical Association, that anesthesiology be recognized as a medical specialty, in connection with hospital service, along with the specialties of surgery, internal medicine, and the like." It was urged in the resolution that anesthesiologists be treated in the matter of pay for their service exactly as other specialists are treated.

Amendments to the Constitution and By-Laws were offered and passed in profusion. The Board of Trustees had made certain recommendations with regard to changes in the laws of the Association, which that group thought would be helpful. Proper amendments were worked out accordingly, introduced, and passed, except for an amendment to the Constitution which, following a parliamentary tangle, may be deemed to be held over until next year, without the blessings of the reference committee to which it had been referred.

Hereafter, no Trustee may serve for more than two terms of five years each; no Councilor may serve for more than three terms of three years each; no member of the Council on Medical De-

fense may be elected for more than two terms of four years each; and no members of the Councils on Scientific Work, Medical Economics, or Postgraduate Medical Education may serve for more than two terms of five years each. The same restriction applies to the Committees on Legislation, Public Relations, Health Problems in Education, Collection and Preservation of Records, Cancer, and Tuberculosis.

The Committee on Tuberculosis was converted from a temporary to a permanent committee, with overlapping five-year terms of office.

The By-Laws were amended so as to require that election of Councilors be made upon nomination of District Medical Societies, made at their regular meetings, or, in the absence of such opportunity, upon nomination of a majority of delegates to the State Medical Association in the councilor districts concerned. Whether this change in policy will serve the purpose intended remains to be seen. There are organizational and mechanical difficulties which must be overcome, and opportunity will offer for just the sort of thing which those who have suggested the change had in mind to obviate.

Dr. A. C. Scott offered an amendment to the Constitution, and a dependent amendment to the By-Laws, covering such a situation as the State Medical Association was confronted with during the recently concluded war, wherein, because of travel restrictions, no meeting of the State Association could be held, and therefore only limited functions exercised. The amendment sought, in effect, to place the Board of Trustees of the Association in a position to do something about it. The amendment to the Constitution and the amendment to the By-Laws were frowned upon by the Reference Committee reporting on them. It was this constitutional amendment which became involved in parliamentary discussion. The question was whether, in fact, a reference committee could condemn a proposed amendment to the Constitution before the amendment was tabled for consideration after the required lapse of a year's time. Of course, it cannot, but the problem was sufficiently keen to cause considerable discussion. Even so, the criticism of the reference committee, which must, we presume, go along with the amendment itself, will probably eventually encompass its defeat.

The Committee on Library Endowment was also converted into a permanent committee, on an overlapping five-year term of office basis. Service on this committee was also limited to two terms of five years each.

The Trustees Report covered two fiscal years. The reports were voluminous and, of necessity, rendered in great detail. It is not possible to enter into any helpful editorial comment on these reports. Suffice it to say that, in the face of many handicaps, the Trustees managed the funds of the Association so well that there was not a hitch or a bobble anywhere. The total assets of the Association at the time of the last audit were $174,789.53. As stated by the Trustees, this total is of necessity variable. During the year, as the cash on hand and on deposit is used up, the total assets will shrink.

The auditor advises that the securities of the State Medical Association are among the few owned by organizations such as our's, which have paid real dividends, and which may be considered as relatively gilt-edged. The budget prepared by the Board of Trustees for the year 1946-1947, which is based on the prospective income of the Association from dues as set up at the present time, and from JOURNAL advertising and other sources, totals $92,100. The prospective income from these sources, is $114,930. The difference between the two, $22,830, will be useful in taking care of expenditures in connection with public relations and the increased cost of management, which the Trustees have not been able to anticipate.

The Trustees reported a revival of interest in the Library of the Association, and the Committee on Library Endowment reported that since the creation of the "Texas Memorial Medical Library Association," which is made up entirely of the Board of Trustees of the State Medical Association, eleven endowments funds of $1,000 each have been established. The Committee also reported that through letters to county medical societies, individual donations through what has been designated "The County Medical Society Library Building Fund," have amounted to $1,543. It will be understood that money paid to the Texas Memorial Medical Library Association is deductable from income tax, and that the only relationship of that organization to the State Medical Association is that it gives this money to the Library of the State Medical Association as the money accumulates and the Library needs it. There would seem to be no reason why, particularly right now, when there is so much money being accumulated by so many people, a sufficient sum might not be secured for the construction and proper operation endowment of a Library of the first class, even second to none of the sort in this country. Money is being given to every sort of project, some of them good, some bad, and some indifferent, and hardly a donor but is under the personal influence of some one or more doctors. It has long been a policy of the Board of Trustees to construct a home and a library for the Association, but the money has come the hard way. It could come the easy way.

The Membership of the Association, according to the report of the Secretary, which was made at the time the books were closed, immediately preceding the annual session at Galveston, was 4,339, with quite a few county societies not having reported at the time. The Secretary broke these figures down as follows: regular members, 4,034; military members, 215; honorary members, 42; intern members, 45; and members emeritus, 3. The total membership was six above that of last year, but the regular membership was much higher. The difference lies between the number of military members then and now, and the fact that many of the military members have again become regular members. at the time the Secretary's report was rendered, it was anticipated that the membership would continue to grow, and at this writing, the total membership has reached 4,763, which is the largest in the history of the Association. Of this total, 4,325 are regular members; 293 are military members; 81 are honorary members; 61 are intern members; and 3 are members emeritus.

The Technical Exhibits at Galveston were, in fact, the "something new" that has been added. We have had no technical exhibits since the last full-dress meeting of the Association, at Houston, in 1942. We have come to look upon our technical exhibitors as part and parcel of our annual sessions, and we have missed them right along with the features of our meetings which we have not had since the beginning of the war. Many of our old friends were back with us, and there were some who have lately come into the fold. But for the necessarily limited space available for the purpose, the list would have been much longer. As a matter of fact, some of our long-treasured friends failed to get booths. One of these applied too late to get

a booth; he headed the waiting list and took the place of an exhibitor who could not make the boat. So impressed was he with the situation, that he applied for a space for next year before we had decided where we would meet next year. In fact, the State Secretary has already had several applications for space for 1947. The latchstring is on the outside for our commercial friends, and will remain there as long as exhibit space is available.

The following were present at Galveston:

BOOKS

The C. V. Mosby Company, St. Louis. Represented by Mrs. S. G. Cooke.

The W. B. Saunders Company, represented by *J. A. Majors Company*, Dallas. Represented by Dr. J. A. Majors, J. A. Majors, Jr., and L. B. Shaver.

DIETETIC SUPPLIES

The Borden Company, New York. Represented by Mr. and Mrs. H. W. Bauer and R. L. Martin.

Mead Johnson & Company, Evansville, Ind. Represented by Edward W. Brady and Earl F. C. Payne.

Paley-Sachs Food Company, Houston. Represented by B. O. Leff and B. L. Golub.

INSTRUMENTS, APPARATUS, AND SUPPLIES

The A. S. Aloe Company, St. Louis. Represented by M. Charles Smith and Mark Leopold.

J. E. Hanger, Inc., Dallas. Represented by Mrs. Sylvia W. E. Findley and Mrs. Mildred Dial.

The Tol. Higginbotham & Company, Dallas. Represented by Paul C. Higginbotham.

Holland-Rantos Company, Inc., New York, Chicago, and Los Angeles. Represented by J. W. Carmichael.

The Hygeia Nursing Bottle Co., Buffalo, N. Y. Represented by C. H. Clark.

The Karmac Company, Dallas. Represented by D. S. McCrary.

W. A. Kyle Company, Houston. Represented by W. A. Kyle, Wolf Goodman, B. Cornelison, Larry McDonald, Jack Heron, and J. L. Kelter.

Luzier's Fine Cosmetics and Perfumes. Represented by R. Ingram-Eiser, C. L. Rice, Miss Lillian Purvis, and Mrs. B. D. Farish.

E. H. McClure Company, Dallas. Represented by F. W. Hilliard.

The Mennen Company, Newark, N. J. Represented by Roy E. Slentz, Frank Holliday, and Tommy Thompson.

V. Mueller & Company, Chicago. Represented by Mr. and Mrs. Ford Dixon.

Pendleton & Arto, Inc., Houston. Represented by J. F. Hury, M. Pat Daley, D. R. Waggoner, David H. Hanna, C. G. Sanderson, and W. R. McPheeters.

Terrell Supply Company, Fort Worth. Represented by O. Coffman, T. S. Curtis, and T. H. Gothard.

The Max Wocher & Son Co., Chicago, Ill. Represented by A. E. Magill.

INSURANCE

Insuromedic Health Service. Represented by R. H. Channell and J. H. Penter.

The Medical Protective Company, Fort Wayne, Ind. Represented by Mr. and Mrs. Herbert Wiggs.

PHARMACEUTICALS AND BIOLOGICALS

Bilhuber-Knoll Corp., Orange, N. J. Represented by J. Smiser Davis and Angus S. Moore.

Cutter Laboratories, Berkeley, Calif. Represented by J. F. Hecker, E. L. Hamilton, and Jim Williams.

Eaton Laboratories, Inc., Norwich, N. Y. Represented by J. J. Manny, V. Threlkeld, A. H. A. Bailey, and William H. Chilner.

First Texas Chemical Manufacturing Company, Dallas. Represented by C. N. Phelps and T. F. Watts.

Lederle Laboratories, Inc., New York. Represented by C. L. Stewart, D. L. Stewart, Maxwell James, Nyles Broyles, and J. A. Clark.

The Eli Lilly and Company, Indianapolis, Ind. Represented by L. A. Williams, W. D. Vinson, and Rex M. Walls.

The Schenley Laboratories, New York. Represented by A. J. Parsons, Dr. McKeown, Mr. Cope, and Mr. Walker.

The Schering Corporation, Bloomfield, N. J. Represented by Scuddy Breaux and M. M. Taliaferro.

Sharp & Dohme, Philadelphia. Represented by G. G. Howard, C. M. Talley, and W. C. Newberry.

White Laboratories, Inc., Newark, N. J. Represented by W. T. Billingsley, Mr. and Mrs. W. F. Alverson, and R. R. Hicks.

X-RAY AND PHYSIOTHERAPY EQUIPMENT

H. G. Fischer & Co., Chicago. Represented by A. E. Magill, H. A. Glover, and Sam Davenport.

General Electric X-Ray Corporation, Dallas, Houston, and San Antonio. Represented by Charles D. Burgy and O. A. Cranford.

The Gilbert X-Ray Company of Texas, Dallas. Represented by M. K. Gilbert and J. D. Murphy.

The Johnson X-Ray and Electro Therapy Company, Dallas. Represented by F. C. Johnson and R. J. Stevenson.

R. P. Kincheloe Company, Dallas. Represented by R. P. Kincheloe, Q. B. Schaefer, and H. D. Wright.

The Southern X-Ray Engineering Company, Houston. Represented by R. J. Fitzsimmons and Harlan Pace.

The United Medical Equipment Company. Represented by Richard Sigman and Eugene Lipsky.

Woman's Auxiliary Transactions Omitted.—Through necessity, the Transactions of the annual session of the Woman's Auxiliary held at Galveston, are omitted from this number of the JOURNAL. They will be published in the July number. It is with much embarrassment and many apologies to all concerned that the JOURNAL management has been forced to resort to this expedient.

The Transactions of the Woman's Auxiliary were in type, had been paged, and were all ready to go to press when we were advised that the size of the JOURNAL would, because of the scarcity of paper, have to be limited. Because of the fact that our own Transactions cover a period of two years, the account of our meeting has required nearly twice as much space as usual. It is simply a physical fact that there is not enough paper to be had to meet the requirement of publishers throughout the country. Indeed, we have been advised that we will be limited during the next year, as to the total number of pages we can print during the year. Perhaps we may say here, as a sort of alibi, that we were lucky enough to secure in the beginning, enough paper to piece out the reduced amount allowed under war restrictions. Many publications have been embarrassingly reduced in size during the war.

THE RESPONSIBILITY OF THE STATE MEDICAL ASSOCIATION WITH REGARD TO POSTGRADUATE MEDICAL EDUCATION IN TEXAS

H. F. CONNALLY, M. D.,
WACO, TEXAS

Before I discuss the subject which I have chosen for my address it is my desire to give full expression to the gratefulness in my heart to those of you who were responsible for elevating me to the exalted position of President of this Association. Unworthy as I may be to lead or direct properly the rapid advance of this body in its scientific achievements in the prevention and cure of disease and in its part in the education of the medical students of our state, most assuredly I realize the full responsibility of the gigantic task which you have intrusted in my hands. It is the greatest honor in the reach of the membership of our Association as a reward for services rendered in its magnificent growth and in its part in medical research. I want you to know that I greatly appreciate the confidence you expressed in me when you showed your willingness to turn over to me the leadership of this Association through such a critical period.

The postwar planning program for industry is being expanded by the very best talent that can be found. Such industries as General Electric, General Motors, the vast transportation companies, and the large manufacturing concerns are employing the very best engineers that can be found for the improvement of their products. Why should not we call into action the very best talent in our ranks to outline a system of expansion for our medical schools and the establishment of larger and better equipped hospitals, both for the care of the sick, the training of interns, and the establishment of residency services that will fully equip young doctors in any specialty they may choose to pursue.

In this address to you I am not taking into consideration the interest of any man or woman except as their interest is in the more abundant facilities and advantages for the development of medical education in Texas. Our efforts should not be halted until we reach the point where we are capable of training our Texas doctors in Texas as they can be trained in any of the large centers of the North and East. For approximately fifteen years, it has been my privilege to serve on the Texas State Board of Medical Examiners. For ten years I have served as Chairman of the Reciprocity Committee, through which service I have been able to check the records of the medical training of many young and middle-aged physicians who have been coming into this state from almost every state in the Union. Having at my disposal a list of the medical schools of all classes in each state, I have acquired some knowledge of what facilities the various medical schools have to offer in the way of teaching medicine.

In 1939 I was chosen by our State Board of Medical Examiners to make an inspection of a rather large number of medical schools in the United States. The purpose of this inspection was to gather information on the different medical schools as to their comparative preparedness to extend medical teaching. The information obtained from the inspection of these schools was to be used to set up a standard for a reputable medical school by which the Texas State Board of Medical Examiners could arrive at an intelligent comparison between a reputable medical school and those which were not so classified. It became necessary to take this action in order to keep our state from being flooded with poorly trained physicians who were coming from the low grade medical schools in the North and East. I inspected several of the very top schools of the country, as well as a similar number of mediocre schools. From these we set up our standard, after which I inspected the low grade schools, the graduates of which were attempting to enter Texas to practice medicine. When all the data had been assembled and a standard set for the approval of our Board, we found it necessary to make some modifications in order that the graduates of our Texas schools would not be excluded from our examinations.

We had two good schools in Texas at that time in comparison to the majority of schools in other southern states. They have made much progress in the past forty years, and have done an excellent job with the facilities at hand, but they have not been able to progress with the major schools of the North and East and with a smaller group in the western states.

The reason for our schools lagging in progress is obvious. They have not been sufficiently endowed. It, therefore, becomes our duty to assist in every way possible to get the required financial support to elevate them to the level of the best schools in the country.

As to postgraduate training in Texas, our schools have practically done nothing. If the graduates of medicine in Texas determine to become specialists in any of the major branches of medicine or surgery, it is neces-

President's Address delivered at the Seventy-ninth Annual Session of the State Medical Association of Texas, Galveston, May 7, 1946.

sary for them to go beyond the borders of this state to get such training.

For several years I have been attending the joint mid-winter meetings of the representatives of the Federated State Medical Boards of America, the National Board of Medical Examiners, and the American boards of the major specialties. These meetings are held in Chicago in February of each year. The purpose of the meetings is to keep up and, where possible, to elevate the standards of the practice of medicine and surgery in the United States. More than twenty years ago, there was organized a National Board of Medical Examiners. The purpose of the organization of this Board was to stimulate the various state boards to raise their standards and, as near as possible, to unify the work of the various boards. Their results have been excellent in improving the standards of all state boards. They have not been so successful in getting a unified standard.

More recently specialty boards have been organized in all major specialties of medicine and surgery. They are the American boards of these specialties. They have set a very high standard for those who desire to become specialists. The Committee on Medical Education and Hospitals of the American Medical Association has encouraged the organization of these specialty boards, and is assisting in making the work of these boards more popular with those who are completing their regular medical college work. In these joint meetings, the Committee on Medical Education and Hospitals of the American Medical Association seems to furnish inspiration to all other groups in their efforts to raise the standards of medical education in every state in the Union.

It has been a source of much satisfaction to me to observe the growth and development of medical science in the past forty years. The millions spent in medical research has paid vast dividends. The results have so clarified many of the old undeveloped ideas of certain medical principles that they are now more easily understood than when many of you and I were attempting to qualify for the practice of medicine.

During recent years, there has been developed in the larger medical centers of the North and East, and to a lesser degree in the West, many super-trained physicians in all these subdivisions of medicine and surgery. At a more recent date, these men have organized examining boards for each of these subdivisions, and have outlined a course of postgraduate training that the young doctors are required to complete before they are privileged to appear before the various specialty boards to qualify for a certification. In the very near future, no Class A hospital will be permitted to place a doctor on its staff as a specialist until he has been certified by the American board of the specialty he proposes to practice. When a physician obtains that certification, he will be recognized by the medical profession of the United States and the world as being qualified to practice as a specialist.

In Texas we now have three medical schools. All are rated Class A, though they are far from being fully equipped as are many of the schools in the larger centers. The lack of funds has curtailed the efforts of our schools; we have not been able to expand our research work which is so necessary to the growth of any medical school or clinic; and the research department in any school must be supported financially if it fulfills its obligations to its students.

Nowhere in Texas is there a place where our young doctors can go for postgraduate training and qualify themselves to pass the American boards of any of the major specialties. We have an ample supply of medical and surgical teachers who are capable of giving the highest quality of instruction, and we have ample clinical material to supply our schools, which material has not been properly assembled, and the facilities for handling this material have not been provided.

If we are going to retain our three medical schools in Texas, we should get behind the efforts that are being made to develop our graduate schools, and likewise support the forward movement that has been started in Dallas and Houston to establish great medical centers, where our young doctors may pursue their hospital training in whatever branch they prefer, and receive the type of supervision during their intern and resident service that will make them as proficient in their chosen specialties as are those who go to the Mayo Clinic, University of Michigan, Harvard, Columbia, Cornell, Southern California, Johns Hopkins, Vanderbilt, or Tulane.

Dr. E. H. Cary has sponsored a medical educational movement in Dallas, and has succeeded in getting the support of the medical profession in that city, which ranks with the best our country affords. He has also obtained the support of the great business interests of the city. They have now a fine start toward the building of a great medical center. When it is completed according to the plans that have been outlined, and with a fine list of material at their command, they will in the next few years be turning out as well trained specialists in every branch of medicine as can be found in any other state in the Union.

Recently it was my pleasure to be present at a large banquet when the M. D. Anderson Foundation presented a deed to a large tract of land in the City of Houston to the Board of Trustees of the Texas Medical Center, and on that occasion a full report was given as to the progress made on the development of that great institution. The map of this Medical Center includes the Herrman Hospital, the Dental Branch of the University of Texas, the M. D. Anderson Hospital for Cancer Research, Library of Houston Academy of Medicine which has recently been presented to the Center, Baylor University College of Medicine, Methodist Hospital, Episcopal Hospital, Jefferson Davis Hospital, Tuberculosis Hospital, Children's Hospital, Institution of Public Health and Geographic Medicine, and there are other hospitals that will be included in the Center. This great Medical Center has the full support of a very capable medical group in Houston, which group comprises the faculty of the Medical Department of Baylor University and many other prominent physicians. Beyond that, they have the support of a great Chamber of Commerce and many prominent public-spirited citizens who are willing and financially able to support such an institution. With this setup, Baylor Medical School will soon become one of the greatest teaching institutions in the country.

The Medical Branch of the University of Texas at Galveston has a fine teaching faculty. They have done a fine job of teaching their students, but for fifty years or more there has been a lack of clinical material, and the situation at Galveston is such that we can not anticipate any material increase of our clinical work.

With this situation confronting us, is it not our duty to come to the assistance of our boys who are finishing the last two years at Galveston? Why should students at the University of Texas School of Medicine be deprived of the advantages offered by the great Medical Center in Houston with its vast amount of clinical material going to waste? The State of Texas should provide the facilities at the Medical Center for the handling of this clinical material in the completion of their junior and senior training. Why should our Texas boys be penalized to the extent of depriving them of the clinical material which is so necessary for their completed medical service when it is so near at hand?

Many of you may be reticent about expressing yourselves, or taking an active part in an effort to bring this suggestion to a successful realization, because of friends who may oppose such a movement on account of some selfish interest. Let us remember that this is our school, and it will be our boys who are to share these advantages or to be deprived of them. The standard of medical practice in Texas will rise to a higher level if such a move is accomplished; likewise, the standard of public health will be raised. If the medical profession in Texas fails to get behind this proposed move, it will be unfaithful to its sons and to medical progress in Texas.

Such a move as is here proposed will result in public benefit, and should not prove detrimental to any person or organization. Certainly no Texans should be embarrassed in giving their full support to such a magnificent service.

Amicable Building.

IN MEMORIAM

WILLIAM L. CROSTHWAIT

WACO, TEXAS

"Only the Living Can Honor the Dead"
(Sali viventes mortuos colunt)

Since last we met a long list of our members and fellow practitioners of Texas have closed their earthly careers. As we meet and mingle we look in vain for familiar faces which we no longer see; we longingly listen for friendly voices which we no longer hear. Their virtues, charities, and fame have been added to the traditions of our noble profession and the glorious history of Texas. Their epitaphs are engraven upon the hearts of the living.

Well do we know that no spoken word can break the silence of their dreamless slumber, nor a million melodies mingled into one harmonious anthem disturb their eternal sleep. What we do and say here cannot benefit those of our honored dead who have paid the last full measure of service and devotion to the altruistic cause of humanity. Therefore, if we the living are not benefited, this service shall have been in vain.

In the good book of Ecclesiasticus we find this noble sentiment, "Honor the Physician with the honor which is due him, for the uses which you may have engaged him." Throughout the ages the above expressions appear to epitomize the attitude of the public toward the medical profession. However, as we follow the history of the rising tide of human advancement in culture, science, social uplift, and ethical evolution we find an ever increasing sentiment and inclination to honor the "physician in life and memorialize him after he passes on." Even before the preacher wrote the book of Ecclesiasticus, which in-

Address delivered at Memorial Services of the State Medical Association of Texas Annual Session, Galveston, May 8, 1946.

cidentally we my say, was deleted from the modern St. James edition of our Holy Bible, there were people who honored the physician for his good works and for his good qualities and memorialized and perpetuated his service to humanity in marble, bronze, poetry, and song. Not so long ago from beneath the shifting sands along the River Nile, there was resurrected a fairly well preserved piece of marble statuary which has been pronounced by archeologists and hierologists as the oldest inscribed monument in existence. It is a wonderful product of sculptural art designed to commemorate the life and work of Imhotep, an Egyptian doctor whose name has been preserved in the annals of authentic history. The hieroglyphics on the statuary have been translated to read, "In Living Memory of Him Who Comes in Peace."

Always, in both peace and war, from the dawn of civilization to this the most disturbing and momentous hour in our entire history, the services and advice of doctors have been a prime and imperative human need and demand.

Our fellow members of this Association and our fellow practitioners of Texas and their good wives to whom on this occasion we pause to pay our humble homage and most profound respects, have served well in both war and peace. They have passed on but they have left the memories of their virtues, achievements, and wealth of their accomplishments as a deep and lasting reservoir which we draw upon for inspiration and determination to press forward to the full realization of their hopes and dreams of a better world. They have bequeathed a legacy of leadership to point our way of professional life. Their example is a shining light growing brighter day by day to light our paths along the road of science and humanitarianism. Therefore this hour should be one of solemn meditation, rededication of the high aims, ethics, faith, and aspiration which motivated the lives of all of those whose memories we this day honor and revere.

We have just concluded a long, cruel, relentless, worldwide war to determine whether or not the civilization—the freedoms and the ethics which our departed members have so nobly advanced—shall endure. And now the war is over. The drone of aircraft and the roar of artillery have faded away in the echoes of the yesterdays, and we find ourselves groping in the murky twilight of an uncertain and unpredictable future. The battle of giants has ended; the quarrel of the pygmies has begun. New ethical perspectives, objectives, and mental horizons have been projected. The memories of our departed members cry aloud, "Beware! Beware, lest ye be deceived!" The voice of our dead cry aloud lest we be lulled into apathy by the siren songs of the nymphs of socialized medicine and become an easy prey to the avarice and greed of political expediency, the devotees of which are determined to place upon the brow of organized medicine a crown of thorns and crucify our noble profession upon a cross of gold.

But be not discouraged. The future looms bright. The end of this world war was climaxed by the most momentous and spectacular achievement in the entire history of the world, man's mastery of atomic energy. The genius of our people is never so stimulated and activated as when confronted by emergency and grim necessity. When the need became imperative for a powerful and awe-inspiring weapon to end the war, the creative genius, the productive faculties and facilities and adequate manpower, and more than two billion dollars of our nation's wealth was quickly assembled to devise the most destruction as to materials and human life ever contrived by man. It is said that creative genius, the constructive mind, the ability to project and contrive, are heaven-born attributes bestowed upon the few for the benefit of all. We cannot believe that the divine Creator would bestow such for the purpose of destruction of his own handiwork and of man created in his own image.

And now a more commanding challenge presents. The war is over but malignant disease stalks the earth and cancer, poliomyelitis, and mysterious virus disease remain unconquered and like a ghostly shadow lurk in the background of all of our lives. Why should we doubt that the same super intelligence, the same inspired creative genius, and the same unlimited material resources may not be commanded to solve the age long problem of malignancy? It is said that no anesthesia is so complete as absorption in one's own work. Many times the busy doctor, keen and alert to detect the first signs of approaching death as that grim monster touches with malignant and unerring design his patient and friend, yet fails to recognize the all too familiar reaper's touch as he lays his cold and relentless hand upon his own tired form. One cannot fail to note the increasingly large number of doctors passing away suddenly in line of duty.

Since Pearl Harbor our ears have been attuned to martial music. We have been thinking largely in military terms—of flaming battle fronts, crashing airplanes, blasted battle ships, and atomic bombs. We have been thinking of our doctors and soldiers wounded or killed in action, of crowded hospitals and transports, of shallow and unmarked graves along our far-flung battle fronts, and too often we have forgotten the

doctor-soldier on the home front, on duty twenty-four hours of the day and night, urged by the needs of his community far beyond the normal limits of his strength and endurance until he drops by the wayside, a war casualty if ever there was one. We find the average age of our beloved members who have passed on is 65 years. So fast is the tempo of the pace which they set and which we must follow that we scarcely have time to say, "Adieu, old pal, bon voyage," but we will not fail to remember. Well do we realize that the poet knew something of human impulses and emotions when he wrote:

"Life is like a highway and
The milestones are the years,
And now and then a toll gate where
We buy our way with tears.

"The road is a long one, sometimes a rough one
And ranges wide and far,
But leads at last to a beautiful city,
Where the golden houses are."

There are many to whom we should like to pay especial homage and respect, some having achieved fame and great renown, yet we are reminded that the very least among those departed may have been the greatest. So we pay our tribute to doctors in general. As a general thing, doctors don't preach, they don't proclaim their virtues, not many of them write, and only rarely do they express themselves to their most intimate and confidential friends and fellow doctors. Too often a doctor rounds out his life in stoical silence as to his worldly aspirations and ambitions, and all too often as to his hopes beyond the tomb. Whatever the pattern of his life may have been, we know that the main objective of each of our departed members was to finish each task each day. We think of each of our departed friends as an ethical, conscientious doctor who closed each day with few regrets and greeted each new dawn with many new aspirations. There are no yesterdays in medicine. The possibilities of today were the probabilities of yesterday. The only limits of the doctor's aspirations of tomorrow are the boundaries of his doubts of today. No specter of academic freedom has ever cast its ghostly shadow across his mental horizon and no mental hazards retard his cerebration. Kipling must have had in mind his old family doctor when he wrote:

"When Earth's last picture is painted, and the tubes are twisted and dried,
When the oldest colours have faded, and the youngest critic has died,
We shall rest, and faith, we shall need it—lie down for an aeon or two.
Till the Master of All Good Workmen shall set us to work anew.

"And those that were good shall be happy: They shall sit in a golden chair;
They shall splash at a ten-league canvas with brushes of comet's hair.
They shall find real saints to draw from—Magdalene, Peter, and Paul;
They shall work for an age at a sitting and never be tired at all!

"And only the Master shall praise us, and only the Master shall blame;
And no one shall work for money, and no one shall work for fame.
But each for the joy of the working, and each, in his separate star,
Shall draw the Thing as he sees It for the God of Things as They are."

And this is the doctor's life, his creed, objectives in life, and his hopes for a full and happy existence beyond the grave. So we say, to our departed, "Good-by, bon voyage, and happy landing."

1724 Austin Ave.

TRANSACTIONS

SEVENTY-NINTH ANNUAL SESSION OF THE STATE MEDICAL ASSOCIATION OF TEXAS

GALVESTON, TEXAS, MAY 6, 7, 8, AND 9, 1946

MONDAY, MAY 6, 1946

Minutes of the House of Delegates

First Meeting

The House of Delegates was called to order by the President, Dr. H. F. Connally, of Waco, at 10:00 a. m., in the Basement Room, Hotel Galvez, Galveston, Texas, with an attendance of sixty-nine delegates.

The Reference Committee on Credentials reported, as follows:

FIRST REPORT OF REFERENCE COMMITTEE ON CREDENTIALS

Dr. Hall Shannon: Mr. President, we have sixty-nine delegates registered.

Secretary Taylor: The Reference Committee on Credentials reports there are sixty-nine delegates present. That constitutes a quorum.

President Connally: We will now hear the roll call.

The roll was called by Dr. Holman Taylor, the Secretary, and the membership of the House of Delegates was established as follows:

MEMBERSHIP OF THE HOUSE OF DELEGATES*

Anderson-Houston-Leon—R. H. Bell.
Angelina—L. H. Denman.
Armstrong-Donley-Childress-Collingsworth-Hall—E. W. Jones.
Bee-Live Oak-McMullen—D. W. Davis.
Bell—A. C. Scott.
Bexar—J. W. Goode, R. E. Parrish, L. B. Jackson, E. D. Dumas.

*SECRETARY'S NOTE: For the sake of convenience the list here published includes all who qualified for membership and who were present some time during the meeting.

Bosque—S. L. Witcher.
Bowie—S. A. Collom.
Brazoria—William Ryan.
Brazos-Robertson—S. C. Richardson.
Brooks-Duval-Jim Wells—John H. Strickland.
Brown-Comanche-Mills-San Saba—J. M. Campbell.
Burleson—George V. Pazdral.
Caldwell—A. A. Ross, Sr.
Cameron-Willacy—R. E. Utley.
Cass-Marion—J. D. Nichols.
Cherokee—J. M. Travis.
Coleman—E. D. McDonald.
Colorado-Fayette—J. H. Wooten.
Comal—A. W. C. Bergfeld.
Cooke—Rufus C. Whiddon.
Dallas—Jo C. Alexander, Edward White, Hall Shannon, C. L. Martin, G. A. Schenewerk, R. E. Trumbull, Tate Miller.
Dawson-Lynn-Terry-Gaines-Yoakum—A. L. Bradford.
Delta—Osler Y. Janes.
DeWitt—H. C. Eckhardt.
Ellis—S. H. Watson.
El Paso—R. B. Homan, Charles F. Rennick.
Erath-Hood-Somervell—T. F. Bryan.
Falls—M. A. Davison.
Galveston—William L. Marr, John J. Delany.
Grayson—W. A. Lee.
Gray-Wheeler—H. E. Nicholson.
Gregg—H. H. Niehuss.
Grimes—S. D. Coleman.
Hardeman-Cottle-Foard-Motley—A. C. Traweek, (Hines Clark).
Harris—John T. Moore, W. E. Ramsay, Hugh C. Welsh, William Snow, Frank Lancaster.
Hays-Blanco—J. M. Van Ness.
Hidalgo-Starr—Alfred S. Osborn.
Hill—Ben C. Smith.
Hopkins-Franklin—J. M. Fleming.
Hunt-Rockwall-Rains—J. W. Ward.
Hutchinson-Carson—L. E. Petty.
Jefferson—L. C. Powell, L. C. Heare.
Johnson—W. P. Ball.
Kaufman—Dave H. Hudgins.
Kerr-Kendall-Gillespie-Bandera—D. R. Knapp.
Kimble-Mason-Menard-McCulloch—D. W. Jordan.
Kleberg-Kenedy—Claunch G. Brindley.
Lamar—Elbert Goolsby.
Lamb-Bailey-Hockley-Cochran—John D. Dupre.
Lampasas-Burnet-Llano—Joe A. Shepperd.
LaSalle-Frio-Dimmit—M. H. Bannister.
Liberty-Chambers—A. R. Shearer.
Limestone—Marion M. Brown.
Lubbock-Crosby—Allen T. Stewart.
McLennan—H. R. Dudgeon, Sr.
Medina - Uvalde - Maverick - Val Verde - Edwards - Real-Kinney-Terrell-Zavala—Cary Poindexter.
Nacogdoches—Stephen B. Tucker.
Navarro—J. Wilson David.
Nolan-Fisher-Mitchell—R. O. Peters.
Nueces—C. P. Yeager, G. T. Moller.
Orange—T. O. Woolley.
Potter—A. E. Winsett.
Runnels—J. W. Dixon.
San Patricio-Aransas-Refugio—John H. Finn.
Shelby-San Augustine-Sabine—W. H. Warren.
Smith—T. M. Jarmon.
Stephens-Shackelford-Throckmorton—H. H. Cartwright.
Tarrant—L. O. Godley, S. J. R. Murchison, C. O. Terrell.
Taylor-Jones—Wayne V. Ramsey.
Tom Green-Coke-Crockett-Concho-Irion-Sterling, Sutton-Schleicher—Victor E. Schulze.
Travis—William M. Gambrell, H. A. Scott.
Walker-Madison-Trinity—L. E. Bush.
Washington—G. A. L. Kusch.
Wharton-Jackson-Matagorda-Fort Bend—R. G. Johnson.
Wichita—P. K. Smith.
Williamson—M. R. Sharp.
Young-Jack-Archer—W. O. Padgett.

Ex-Officio Membership House of Delegates

President—H. F. Connally, Waco.
President-Elect—C. C. Cody, Houston.
Vice-President—R. G. Johnson, Newgulf.
Vice-President—E. W. Wright, Bowie.
Vice-President—H. E. Whigham, McAllen.
Secretary—Holman Taylor, Fort Worth.
Board of Trustees—Sam E. Thompson, Chairman, Kerrville; T. C. Terrell, Secretary, Fort Worth; W. B. Russ, San Antonio; E. W. Bertner, Vice-Chairman, Houston.
Board of Councilors—E. A. Rowley, Amarillo; R. E. Windham, San Angelo; C. E. Scull, Chairman, San Antonio; W. E. Whigham, McAllen. R. A. Wilson, Secretary, Austin; F. J. L. Blasingame, Wharton; J. E. Clarke, Houston; A. E. Sweatland, Lufkin; Leroy Trice, Palestine; G. V. Brindley, Temple; C. C. Nash, Dallas; C. A. Smith, Texarkana.
Council on Medical Defense—W. D. Jones, Dallas; A. P. Howard, Houston; W. A. King, Pandora.
Committee on Legislation—H. F. Connally, Waco; Holman Taylor, Fort Worth; J. H. Burleson, San Antonio; L. H. Reeves, Fort Worth; J. Allen Kyle, Houston.

President Connally: We will have the reading of the minutes of the previous meeting.

Secretary Taylor: The minutes of the previous meeting of this House of Delegates, which was held at Waco, November 13, 1945, will be found beginning on page 216 of the December, 1945, number of the Texas State Journal of Medicine.

Upon motion of Dr. C. P. Yeager, of Corpus Christi, seconded by Dr. A. E. Sweatland, of Lufkin, the reading of the minutes of the previous meeting was dispensed with, and the minutes as edited and published in the December, 1945, number of the Texas State Journal of Medicine, were adopted.

President Connally: The Secretary will read the Reference Committee appointments.

The Secretary announced the appointment of the Reference Committees of the House, as follows:

Reference Committee on Credentials—Hall Shannon, Dallas; E. W. Jones, Wellington; J. M. Campbell, Goldthwaite; L. O. Godley, Fort Worth.
Reference Committee on Reports of Officers and Committees—L. B. Jackson, San Antonio; J. T. Darwin, Decatur; Victor E. Schulze, San Angelo; L. H. Denman, Lufkin; Rufus Whiddon, Gainesville.
Reference Committee on Resolutions and Memorials—A. A. Ross, Lockhart; S. L. Witcher, Clifton; C. O. Terrell, Fort Worth; M. A. Davison, Marlin.
Reference Committee on Finance—W. A. Lee, Denison; A. C. Traweek, Sr., Matador; G. A. L. Kusch, Gay Hill; R. G. Johnson, Newgulf; J. M. Travis, Jacksonville.
Reference Committee on Amendments to the Constitution and By-Laws—H. R. Dudgeon, Waco; I. T. Shotwell, Littlefield; A. R. Shearer, Mont Belvieu; Joe A. Shepperd, Burnet.
Reference Committee on Scientific Work—T. M. Jarmon, Tyler; J. G. Burns, Cuero; O. Y. Janes, Cooper; William L. Marr, Galveston; J. L. Goforth, Dallas.
Reference Committee on Medical Service and Public Relations—S. H. Watson, Waxahachie; George A. Schenewerk, Dallas; S. D. Coleman, Navasota; Charles P. Yeager, Corpus Christi; J. W. Ward, Greenville.

President Connally: The Secretary's report.

The Secretary then read his annual report, as follows:

REPORT OF THE SECRETARY

This report will, of necessity, cover a period of two Association fiscal years, 1944-1945 and 1945-1946. This is true because there has been no "Annual Meeting" of the House of Delegates since May, 1944. There was a Called Meeting of the House of Delegates on November 13, 1945, but the amount of business eligible to come before that meeting was so limited that annual reports were not in order. Two items from the Report of the State Secretary were taken up and acted upon, they having been determined as eligible for consideration at the called meeting. These two items comprised a list of nominations for Honorary Membership, and two pending Amendments to the Constitution of the State Medical Association. Both of these items were published under the Transactions of the meeting, in the December, 1945, number of the JOURNAL.

Procurement and Assignment Service has been gradually changing in character for the past two years. The problem of relocating physicians returning from the Armed Forces and re-entering private practice speedily became an important feature of the service, until Procurement and Assignment Service was discontinued in Texas, April 1, 1946, at which time the Central Office took over the work of the committee, as a part of the work of the State Medical Association proper. This problem will be reported upon more in detail, at this meeting, by the Procurement and Assignment Committee.

For the first time in four years, a full-dress Annual Session of the State Medical Association will be held this year. It had been anticipated that such a meeting would be held in 1945, and every effort was made to so arrange. However, it developed that war restrictions prevented such a meeting. Even so, the Council on Scientific Work had in the meantime prepared a complete scientific program. It was understood when the scientific program was being arranged, that all papers prepared for presentation at such a meeting would be published in the JOURNAL if the meeting were not held. The meeting was not held, and those papers have, very largely, been so published.

An effort was then made to get permission from the War Committee on Conventions of the Office of Defense Transportation to hold a meeting of our House of Delegates. This effort failed, and no such meeting was held until November 13, 1945, and that meeting was not considered a regular annual meeting, hence, as already stated, very little business could be transacted.

The following changes have occurred in the Official Family during the past two years:

Dr. J. Edward Johnson, Councilor for the Thirteenth District, resigned his office, because of removal from Mineral Wells to Austin, and Dr. O. B. Kiel, of Wichita Falls, was appointed to fill the unexpired term.

Dr. W. E. Ryan, of Midland, Councilor for the Second District, was killed, October 14, 1944, in France, while serving with the Armed Forces, and Dr. A. H. Fortner, of Sweetwater, Vice-Councilor for the District, was appointed to fill the unexpired term.

Dr. J. G. Webb, of Mercedes, Councilor for the Sixth District, died April 17, 1946. Dr. W. E. Whigham, of McAllen, was appointed to fill the vacancy thus created.

Dr. J. Allen Kyle, of Houston, was appointed to fill the unexpired term of Dr. Olin F. Gober, of Temple, on the Committee on Legislation. Dr. Gober died January 26, 1946.

A vacancy was created on the Committee on Health Problems in Education, by the death of Dr. H. H. Ogilvie, of San Antonio, on June 15, 1945. The vacancy has not been filled.

The death of Dr. O. F. Gober on January 26, 1946, created a vacancy on the Committee on Malaria, which vacancy has not been filled.

Two vacancies have occurred on the Committee on Transportation, neither of which has been filled. The vacancies were created by the deaths of Dr. O. F. Gober on January 26, 1946, and Dr. Judson L. Taylor, of Houston, on November 28, 1944.

A number of changes have been made in the list of Officers of Scientific Sections, because of the necessity of holding over the entire group for a second period. They are as follows: Dr. Edwin L. Rippy, of Dallas, succeeded Dr. Gladys Fashena, of Dallas, as Secretary of the Section on Medicine; Drs. V. R. Hurst, of Longview, and Burbank Woodson, of Temple, succeeded Drs. Sam N. Key, of Austin, and C. S. Sykes, of Galveston, as Chairman and Secretary, respectively, of the Section on Eye, Ear, Nose, and Throat; Dr. Glenn D. Carlson, of Dallas, succeeded Dr. Asa E. Seeds, of Dallas, as Secretary of the Section on Radiology and Physiotherapy; Drs. George A. Gray, of San Angelo, and L. P. Walter, of Austin, succeeded Drs. Victor E. Schulze, of San Angelo, and T. E. Dodd, of Austin, as Chairman and Secretary, respectively, of the Section on Public Health; Drs. M. C. Carlisle, of Waco, and Robert L. Moore, of Dallas, succeeded Drs. C. B. Alexander, of San Antonio, and Francis A. Garbade, of Galveston, as Chairman and Secretary, respectively, of the Section on Pediatrics.

The *Committee on Public Relations* became a committee of the Board of Trustees, by action of the last meeting of the House of Delegates, with Dr. C. S. Venable of San Antonio, as Chairman. The office of the Committee was consolidated with the Central Office of the Association at Fort Worth. Dr. Venable resigned as Chairman of the Committee, and was succeeded in that office by Dr. R. B. Anderson, of Fort Worth. Dr. Walter G. Stuck, of San Antonio, who had been Co-Chairman with Dr. Merton M. Minter, of San Antonio, also resigned. The Committee was re-organized at this time, with the following personnel: Dr. R. B. Anderson, Chairman, Fort Worth; Drs. Merton M. Minter and R. A. Miller, San Antonio; Frank A. Selecman, Dallas, and W. A. Coole, Houston. Later in the year, Dr. Coole resigned, and Dr. E. Trowbridge Wolf, of Houston, succeeded him as a member of the committee.

The published Minutes of the 1944 Meeting of the House of Delegates show Dr. J. Allen Kyle, of Houston, elected to succeed himself as a member of the Legislative Committee of the State Association. This and related matters were commented upon in the August, 1944, number of the JOURNAL (page 221). This editorial comment, and a quotation from the record, are too voluminous to include in this report. It is hoped that those who are interested in the matter will read the editorial comment here referred to. The State Secretary was forced to conclude that Dr. Kyle had not been elected to succeed himself, and that the nomination first made by our President-Elect was not confirmed by the House of Delegates. In the face of this dilemma, appeal was made to the General Attorney of the Association, whose opinion, it is felt, should be presented in this report. It follows:

OPINION OF THE GENERAL ATTORNEY OF THE STATE MEDICAL ASSOCIATION

"Section 8 (a-5), dealing with the Committee on Legislation provides in part as follows:

"' * * *The President-Elect *shall* appoint to fill vacancies created by expiration of term of office.

' * * * These appointments *shall* be con-

firmed by the House of Delegates, and *shall* be considered at the time of election of officers.'

"It is evident that the above quoted provisions are mandatory rather than directive.

"The record of the proceedings of the House of Delegates furnished with your letter shows the President-Elect nominated Dr. Crabb for the vacancy on the Committee on Legislation. It appears from the record that in addition to the name of Dr. Crabb the presiding officer permitted the name of Dr. Kyle to be placed in nomination, also. A vote was taken and Dr. Kyle received a majority of the votes. This action resulted in disapproval by the House of Delegates of the nomination of Dr. Crabb, who was nominated by the President-Elect. Inasmuch as Dr. Kyle was not nominated by the President-Elect, his election by the vote of the House of Delegates was not in accordance with the plain, mandatory provisions of the By-Laws of the Association. It, therefore, results that no one was selected in accordance with the By-Laws to fill the vacancy on the Committee on Legislation. In accordance with the plain, mandatory provision of the above by-laws, a portion of which has been quoted, the vacancy can only be filled by the confirmation by the House of Delegates of the appointment made by the President-Elect at the time of the election of officers. It therefore follows that the vacancy must exist until such time as the House of Delegates shall confirm an appointment of the President-Elect, which confirmation, as provided by the By-Laws, must be made at the time of the election of officers.

"The record shows that during the proceedings of the House of Delegates, the presiding officer, in due order, announced the expiration of the term of Dr. W. S. Barcus on the Committee on Health Problems in Education. The presiding officer stated that the nomination was to be made by Dr. Connally, President-Elect. Dr. Connally thereupon stated that he was going to turn that over to the membership on the floor, as to whom the membership wanted nominated.

"The same procedure occurred when the question as to the nomination from the President-Elect to fill the vacancy on the Committee on Cancer, due to the expiration of the term of Dr. Caldwell, was announced by the presiding officer. The President-Elect announced he would turn that over to the floor.

"In the case of the vacancy on the Committee on Health Problems in Education, Dr. Barcus was elected to succeed himself by acclamation. Dr. George T. Caldwell was duly nominated to succeed himself as a member on the Committee on Cancer, and he was duly elected by acclamation.

"Section 9 (a-6) of the By-Laws, dealing with the Committee on Health Problems in Education, contains the same provisions as to the filling of vacancy created by the expiration of term of office as is provided for the filling of vacancy on the Committee on Legislation. The same is true as to the provision of Section 11 (a-8) of the By-Laws, providing for the filling of vacancy created by expiration of term of office on the Committee on Cancer.

"The President-Elect's statement with reference to the selection to fill vacancies on the Committee on Health Problems in Education, and on the Committee on Cancer, seems to me amounted to a relinquishment of the authority on his part to make the appointment, and a delegation thereof to the membership of the House of Delegates to make the appointment. Under such circumstances, it appears to me that the House of Delegates, being a deliberative body regularly in session, had the right to deal with the condition thus presented by taking the matter in its own hands, in accordance with the President-Elect's express wish that it do so. It is clearly contemplated that the Committee on Health Problems in Education and the Committee on Cancer, shall function. I believe the House of Delegates had the power, when the regular procedure for the selection of these committees was made impossible, to take the matter in its own hands and in its own way and by the method pursued fill the vacancies on said committees.

"I conclude that there is no vacancy on either the Committee on Health Problems in Education or the Committee on Cancer, but that there is a vacancy on the Committee on Legislation, which will exist until such time as it is filled in the manner and at the time provided under Section 8 (a-5) of the By-Laws of the Association."

President Dr. Connally appointed Dr. O. F. Gober, of Temple, to fill the vacancy in question. It did not seem that the appointment was properly made, in that while the President is authorized by the By-Laws to fill all vacancies *not otherwise provided for in the By-Laws*, the fact remains that filling the vacancy in question *is otherwise provided for in the By-Laws*. The procedure set out for filling a vacancy created by expiration of term of office is through nomination by the President-Elect and confirmation by the House of Delegates. A vacancy created by death, resignation or any other such cause, undoubtedly should be filled by the President of the Association. The Executive Council of the Association, at a meeting held March 14, 1945, approved the appointment of Dr. Gober to the position in question, and recommended that the House of Delegates confirm the same.

It still does not seem that the procedure is in accord with our By-Laws, but the State Secretary accepted the decision of the Executive Council, pending final determination of the House of Delegates. There is grave doubt whether any parliamentary procedure can be devised whereby an act of the House of Delegates in connection with the vacancy in question can be undone. The proper procedure to be followed in filling this vacancy is through nomination by the President-Elect and confirmation by the House of Delegates at the time of election of officers of the Association. Dr. Gober received all communications going to the Legislative Committee, and in general was recognized as a member of the committee.

Dr. Gober died January 26, 1946, and Dr. J. Allen Kyle, of Houston, was appointed to fill the vacancy thus created on the Committee on Legislation. Manifestly, if the appointment of Dr. Gober was not valid, neither was the appointment of Dr. Kyle. However, in view of the decision of the Executive Council to recognize the appointment of Dr. Gober, the State Secretary has felt that he should do the same thing, and Dr. Kyle has been recognized as a member of the committee.

Membership.—Statistical reference to the membership of the Association for the fiscal year 1944-1945 was rather more involved and perhaps less clear than usual. Military membership had been charged for at the rate of $1.00 per year, which amount was set up in order to cover Medical Defense. Subscription to the JOURNAL was omitted from the re-arrangement of military membership, for the double reason that there had been a desperate scarcity of paper, and the postoffice authorities had been complaining of much congestion. In short, it would have been exceedingly difficult to furnish all of our military members with the JOURNAL, not altogether because of the scarcity of paper, but as well because of mailing difficulties, including lack of addresses. At the time the books were closed at the end of the fiscal year 1943-1944, there were 4,258 members, which included 3,177 Regular Members; 1,019 Military Members; 44 Honorary Members; 14 Intern Members, and 4 Members Emeritus. When the books were closed at the end of the fiscal year 1944-1945 (on April 30, 1945), the total membership was 4,333, which included 3,234 Regular

Members, 1,031 Military Members, 40 Honorary Members, 25 Intern Members, and 3 Members Emeritus.

The Trustees reported upon the money differences for the same period. There had been an actual gain in membership, and a considerable gain in money. There were 75 more members that year than the year before, and, according to the Report of the Trustees, an increase in money of $37,146.00. The seventy-five additional members alone, under the new dues ($20.00 for regular members and $1.00 for military members) would have produced the sum of $2,578. The increase in income was deemed necessary to take care of the cost of our Public Relations activities, and the normal increase in cost of the ever-increasing activities of the Association. It is a pleasure to report this state of affairs, in view of the fear that many of us had that there would be a temporary falling off of membership, and while a considerable falling off would be required actually to lose money, the money value of membership is not the real desideratum.

For the fiscal year ending April 23, 1946, the total membership was 4,339, with quite a few county medical societies either not reporting at all, or incompletely. This membership may be broken down as follows: Regular Members, 4,034; Military Members, 215; Honorary Members, 42; Intern Members, 45; and Members Emeritus, 3.

It will be noted that the total membership is six above that of last year, while the regular membership is considerably above that at the time of the report last year. The difference lies, of course, between the number of Military Members reported now and last year. At the time of our report last year, there were 1,031 Military Members, whereas there are at this time 215 Military Members, and the list of military members will continue to grow smaller and smaller.

The difference between regular membership and military membership makes a considerable difference in finances, concerning which matter the Board of Trustees will report in full.

County Society Reports.—The following societies have failed to file annual reports: Delta, El Paso, Fayette, Hidalgo-Starr, Morris, Nueces, and Randall-Deaf Smith-Parmer-Castro-Oldham.

The following county societies report less than the required five members: Burleson, Lee, and Scurry-Dickens-Kent-Garza-Borden-King-Stonewall.

New County Society Charters.—The Armstrong-Donley-Childress-Collingsworth-Hall Counties Medical Society was chartered February 26, 1945, being a combination of the former Donley-Armstrong Counties Medical Society, and the Childress-Collingsworth-Hall Counties Society.

Honorary Members.—The following Honorary Members died during the past two years:

Dr. Sigmund S. Burg, Houston, formerly of San Antonio (December 25, 1944).

Dr. Joe E. Daniel, Houston (July 28, 1944).

Dr. A. Judson James, Houston (August 25, 1945).

Dr. Robert L. Hargrave, Wichita Falls (January 29, 1946).

Dr. S. B. Kirkpatrick, Taylor (August 4, 1944).

Dr. James S. McKown, Osceola (September 13, 1944).

Dr. S. D. Moore, Van Alstyne (October 15, 1944).

Dr. J. Mark O'Farrell, Houston (May 23, 1945).

Dr. Oscar C. Pabst, Tyler (October 14, 1944).

Dr. Charles M. Rosser, Dallas (January 27, 1945).

Dr. Edmond Henri Sauvignet, Laredo (January 27, 1945).

Dr. J. A. Stanfield, Fort Worth (November 4, 1945).

Dr. G. Graham Watts, San Antonio (July 11, 1945).

The following *Member Emeritus* died since the last Report:

Dr. Edward Randall, Sr., Galveston (August 12, 1944).

There still seems to be uncertainty as to the method of terminating Honorary Membership. The absence of the name of an honorary member from the annual report of his county society actually terminates his membership. No action is necessary on the part of anybody. Any other membership may be renewed at any time during the calendar year by the simple expedient of paying dues. Presumably this covers honorary membership. After the expiration of the calendar year, it is required that a former member desiring to renew his membership re-apply therefor. The same rule would apply to honorary membership, but methods of election will, of course, differ. An honorary member must be nominated by his county society, the nomination must be approved by the Board of Councilors, and the House of Delegates must elect.

The following nominations for Honorary Membership have been made by their respective county medical societies:

Anderson-Houston-Leon Counties: Dr. A. L. Hathcock, Palestine, born 1867, member of the State Medical Association continuously from 1904 through 1946.

Anderson-Houston-Leon Counties: Dr. Joseph H. Paxton, Elkhart, born 1866, member of the State Medical Association 1904-1912; 1914-1917; 1925 through 1941.

Armstrong-Donley- Childress - Collingsworth - Hall Counties: Dr. Edgar W. Moss, Pharr, born 1882, member of the State Medical Association from 1912 through 1946.

Brazos-Robertson Counties: Dr. H. W. Cummings, Hearne, born 1868, member of the State Medical Association continuously from 1904 through 1946 with the exception of the year 1945.

Cameron-Willacy Counties: Dr. Benjamin L. Cole, Brownsville, born 1871, member of the State Medical Association from 1920 continuously through 1946.

Ector-Midland-Martin-Howard-Andrews-Glasscock Counties: Dr. G. S. True, Big Spring, born 1866, member of the State Medical Association 1906-1909; 1916-1941; 1943-1944.

El Paso County: Dr. A. H. Butler, El Paso, born 1873, member of the State Medical Association 1908-1912; 1919-1921; 1927; 1929 through 1945.

El Paso County: Dr. Brown W. Randel, El Paso, born 1891, member of the State Medical Association 1915; 1922 through 1944.

El Paso County: Dr. Samuel D. Swope, El Paso, born 1864, member of the State Medical Association from 1923 continuously through 1946, with the exception of the year 1925.

Falls County: Dr. S. S. Munger, Marlin, born 1869, member of the State Medical Association 1910-1911; 1916-1927; 1929-1930; 1932; 1935-1939; 1941-1942.

Jefferson County: Dr. S. Ross Jones. Waco, formerly of Port Arthur, born 1886, member of the State Medical Association 1916-1925; 1927-1929; 1932 through 1945.

Milam County: Dr. Albert S. Epperson, Houston, formerly of Cameron, born 1869, member of the State Medical Association continuously from 1904 through 1945.

Milam County: Dr. Isaac P. Sessions, Rockdale, born 1867, member of the State Medical Association 1904-1912; 1914; 1916-1932; 1934-1944.

Nueces County: Dr. Alfred W. Davison, Corpus Christi, born 1867, member of the State Medical Association continuously from 1908 through 1945, with the exception of the year 1939.

Potter County: Dr. James B. Ozier, Amarillo,

born 1877, member of the State Medical Association continuously from 1917 through 1946.

Taylor-Jones Counties: Dr. M. E. Campbell, Abilene, born 1872; member of the State Medical Association 1905-1906; 1908 through 1944.

Taylor-Jones Counties: Dr. Claude B. Leggett, Abilene, born 1880, member of the State Medical Association 1908-1909; 1911; 1915; 1918 through 1944.

Tom Green-Eight Counties: Dr. Walton W. Cobb, Fort Worth, formerly of San Angelo, born 1873, member of the State Medical Association continuously from 1910 through 1946.

Election of Officers.—In view of the circumstances, it seems advisable that this House of Delegates, by formal action, determine its policy in the matter of continuity of term of office. The State Secretary has assumed that term of office expires with the administration, and the year 1944-1945 has been disregarded entirely in computing the terms of office of all officers, councils, and committees, since no meeting of the House of Delegates was held during that period that permitted changes of such officers. It is important that the Reference Committee to which this report will go, make specific recommendations to the House of Delegates so that official action may be taken on the matter prior to the election of officers on the last day of the annual session.

Finally, I would like the privilege of a personal word in appreciation of the services of the staff of the Central Office, particularly those of my associate, Dr. Anderson. Except for an unusual and high order of devotion and competency, the work of the Association could hardly have been carried through so efficiently and effectively as I believe has been the case. There have been unusual difficulties in the employment of competent help. There have been many exceptional and unlooked for situations, and conditions have constantly arisen in which there have been no precedents. The sudden illness of Dr. Anderson, occurring as it did in the midst of preparations for the annual session, has been an impediment difficult to overcome in numerous particulars. Dr. Anderson and the staff join me in appreciation of the patience and tolerance of our members, and for the messages of encouragement and good cheer which have come to us from time to time.

Respectfully submitted,

HOLMAN TAYLOR, Secretary.

President Connally: The report of the Secretary will be referred to the Reference Committee on Reports of Officers and Committees, except that part carrying nominations for honorary membership, which list of names is referred to the Board of Councilors acting as a Reference Committee.

Next, the report of the Treasurer.

Secretary Taylor: The Treasurer is not present. I am authorized by him to submit his report.

TREASURER'S REPORT

As of April 30, 1945

The facts and figures pertaining to the accounts of the Treasurer are reflected in the auditor's report, which will be submitted by the Board of Trustees, and to which I refer.

There is cash in the Treasury, as of April 30, 1945, in the sum of $57,312.56, on deposit with the Fort Worth National Bank of Fort Worth, Texas. In addition, the sum of $1,475.24 is on deposit with the First National Bank of Fort Worth, and $80.00 is held in the office of the State Secretary, for which latter two amounts the Secretary is responsible.

During the period from April 25, 1944, to April 30, 1945, cash from all sources was received in the aggregate amount of $112,569.76. Disbursements from the Treasurer's account to the Association Operating, or Secretary's account, totaled $85,020.00, and bank collection charges were $0.92. The balance on deposit in the Treasurer's account at the beginning of the period was $29,763.72, and at the close of the period, as stated above, $57,312.56.

Analysis showing changes effected in the Investments of the Association during the past year is as follows:

Investments—April 25, 1944	$64,446.26
Additions:	
U. S. Savings Bonds, Series "G"	13,600.00
	$78,046.26
Sale at par of Home Owners Loan Corporation Series A 3% Bonds	13,600.00
Investments—April 30, 1945	$64,446.26

A schedule of the investments is submitted in the audit report.

During the year interest and dividends in the aggregate amount of $2,645.00 were received on the above securities.

As Treasurer of the Texas Memorial Medical Library Association, I report the following investments of said Association as of April 30, 1945:

Shares of Building and Loan Associations	$3,000.00
U. S. Savings Bonds, Series "G"	6,000.00
	$9,000.00

Summary of cash transactions of the Library Association for the past fiscal year is as follows:

Cash on Deposit—April 25, 1944		$ 96.82
Receipts:		
Woman's Auxiliary of State Medical Association for:		
The Romayne Ray Memorial Fund	$1,000.00	
The Presidents' Library Endowment Fund	1,000.00	
County Societies for Library Building Fund	385.00	
Income from Investments	215.00	2,600.00
		$2,696.82
Disbursements:		
Purchase of U. S. Savings Bonds Series "G"		2,000.00
Cash on Deposit—April 30, 1945		$ 696.82

Reference is made to audit report of the Texas Memorial Medical Library Association for more detailed information in this connection.

Respectfully submitted.

K. H. BEALL, Treasurer.

We certify that the above is correct as disclosed by audit.

McCAMMON, MORRIS, PICKENS & MAYHEW.

TREASURER'S REPORT

As of April 23, 1946

The facts and figures pertaining to the accounts of the Treasurer of the State Medical Association of Texas are reflected in the auditor's report, which will be submitted by the Board of Trustees, and to which I refer.

There is cash in the Treasury, as of April 23, 1946, in the sum of $82,878.97, on deposit with the Fort Worth National Bank of Fort Worth, Texas. In addition, the sum of $8,590.61 is on deposit with the First National Bank of Fort Worth, and $80.00 is held in the office of the State Secretary, for

which latter two amounts the Secretary is responsible.

During the period from May 1, 1945, to April 23, 1946, cash from all sources was received in the aggregate amount of $134,867.33. Disbursements from the Treasurer's account to the Association Operating, or Secretary's account, totaled $109,300.00, and bank collection charges were $0.92. The balance on deposit in the Treasurer's account at the beginning of the period was $57,312.56, and at the close of the period, as stated above, $82,878.97.

Analysis showing changes effected in the Investments of the Association during the past year is as follows:

Investments—May 1, 1945		$ 64,446.26
Additions:		
15 Shares American Telephone & Telegraph Co. stock—common—Par Value $100.00 per share		2,107.80
U. S. Savings Bonds, Series "G"		20,000.00
		$ 86,554.06
Reductions:		
American Telephone & Telegraph Co. 3% Temporary Debenture Bonds, exchanged for Common stock shown above	$ 1,507.80	
Principal Payments—John H. Freeman notes	14,500.00	16,007.80
Investments, April 23, 1946		$ 70,546.26

A schedule of the investments is submitted in the audit report.

During the year interest and dividends in the aggregate amount of $3,147.37 were received on the above securities.

As Treasurer of the Texas Memorial Medical Library Association, I report the following investments of said Association as of April 23, 1946:

Shares of Building and Loan Associations	$ 3,000.00
U. S. Savings Bonds, Series "G"	6,000.00
U. S. Savings Bonds, Series "F"	1,480.00
	$10,480.00

Summary of cash transactions of the Library Association for the past fiscal year is as follows:

Cash on Deposit—May 1, 1945		$ 696.82
Receipts:		
Woman's Auxiliary of State Medical Association	$ 175.50	
County Societies for Library Building Fund	1,143.00	
Dr. V. R. Hurst for Longview Foundation Fund	100.00	
Income from Investments	225.00	1,643.50
		$ 2,340.32
Disbursements:		
Remittance to State Medical Association of Texas, for the use and benefit of the library of said Association		434.56
Cash on Deposit, April 23, 1946		$ 1,905.76

Reference is made to audit report of the Texas Memorial Library Association for more detailed information in this connection.

Respectfully submitted,

K. H. Beall, Treasurer.

We certify that the above is correct as disclosed by audit.

McCammon, Morris, Pickens & Mayhew

The Treasurer's report was referred to the Reference Committee on Finance.

President Connally: The report of the Board of Trustees.

Dr. E. W. Bertner, of Houston, Vice-Chairman of the Board of Trustees, then presented the Report of the Board of Trustees, as follows:

REPORT OF THE BOARD OF TRUSTEES

Fiscal Year 1944-1945

The fiscal year just concluded has been replete with the difficulties incident to the war which were mentioned in the last report of the Board of Trustees. There has been variation in the additional demands over those of the year before, but they have been as exacting and as difficult to handle from the standpoint of administration as they have heretofore been. It is desired that the matter be mentioned here, in order that the House of Delegates may appreciate the service that the Central Office has rendered under such difficult conditions.

The matter of military membership has been settled quite satisfactorily, it appears, at least for the time being. A further report will be made in connection with the analysis of the membership situation in general.

The problem of Procurement and Assignment, while still pressing, has ceased to be of the diverting concern which it has heretofore been. The Central Office continues to contribute the services of the State Secretary, and particularly of his associate, Dr. Anderson, but the stenographic and clerical work of the service is now rendered by governmental employees. The cost of communication, whether by letter, telephone or telegram, and necessary travel in connection with Procurement and Assignment Service, is assumed by the government. The Trustees are prepared to extend to Procurement and Assignment Service such assistance as may be necessary in relocating physicians throughout the State, upon their return from service with the armed forces. How this program will develop, remains to be seen. The American Medical Association has set up a Bureau of Information in its offices for the compilation of data which will be made available to medical officers returning from service, who are seeking location for private practice. The Bureau will work in close coöperation with the Joint Committee on Postwar Medical Service of the American Medical Association, and with similar committees of the state medical associations and Procurement and Assignment Service. Proper authority in the State Medical Association will be brought to bear on the situation.

The committee on Procurement and Assignment will make its own report to this House of Delegates.

Public Relations Committee.—It will be recalled that an amendment to the By-Laws was adopted at the 1944 meeting of the House of Delegates, providing that the Board of Trustees appoint a Public Relations Committee of five members, and direct the work and activities of such Committee, in the interest of the Association. In carrying out the provisions of the by-law referred to, we appointed the following Public Relations Committee immediately after the 1944 Annual Session: Dr. C. S. Venable, Chairman; Dr. Merton Minter, Dr. Walter G. Stuck, Dr. R. A. Miller, San Antonio, and Dr. Walter A. Coole, Houston, the appointments having been cen-

tered in San Antonio because the previous committee appointed by Dr. Venable, as President, had been located there and had employed the firm of Aniol and Auld, of San Antonio, to take care of the administrative work of the Committee. At the request of the Chairman, Dr. Venable, a number of other members were appointed to the Committee to help carry on its work throughout the State. The names of these appointees are listed in the report of the Committee on Public Relations, as sectional advisers, which was done after the Committee was reorganized by the Board in November, 1944.

In order to give proper study and supervision to the work of this Committee, three meetings of the Board, held during the past year, were devoted largely to this activity. On November 1, 1944, Dr. C. S. Venable tendered his resignation as Chairman of the Committee, which was regretfully accepted. We wish to express here our appreciation of the time and talented effort expended by Dr. Venable in this work. He made an important contribution to our Association in its pioneering in public relations, for which we are indebted to him. This expression of appreciation goes equally to Dr. Stuck, who also resigned because of pressure of other work.

After Dr. Venable resigned, decision was made to move the office of the Committee to the Central Office of the Association in Fort Worth, as a matter of economy of effort, time and money, and also with the thought that the Committee's work might be better integrated with all of the activities of the Association. The Committee was reorganized, and a complete account of its work following its reorganization, as given in a report of the Public Relations Committee, signed by R. B. Anderson, Chairman; Merton Minter, R. A. Miller, and Frank Selecman, has been approved by the Board and will be presented to the House of Delegates, at the direction of the Board, when the House of Delegates convenes. Very recently Dr. Walter A. Coole, of Houston, resigned from the Committee, and Dr. E. T. Wolf, of Houston, was appointed to fill the vacancy.

The Board has attempted to see that a sound public relations program is put in operation without waste of money and with promise of desired results. Until it was known how much money would be available from the increase in dues voted by the Association for this work, it was thought that caution should be exercised in connection with expenditures. The increase from the dues did not become available until January 1, 1945, and the Committee began its work, for the past administration, in May, 1944. It will be recalled that prior to the raise in dues to provide funds for this activity of the Association, appeals were made for donations. Last year we reported that up to April 30, 1944, a total of $3,677.75 had been donated. From May 3, 1944, to the present time, only $152.00 was received in donations. The Board decided not to solicit any further donations after the 1945 dues, with the increase referred to, became available.

The Committee was given a budget of $9,000 for its work from June 1 to December 1, 1944, or $1,500 per month. At a meeting of the Board of Trustees on October 8, 1944, an allowance of $1,000 per month was made available for the Committee, from December 1, 1944, to May 1, 1945, with the understanding that at any time the Committee needed more money for any emergency, the Board would meet immediately and give consideration to the need. Because of reasons set forth in the report of the Committee, the allowance for public relations activities has been more than ample, the total expenditures from May 1, 1944, to May 1, 1945, having been only $9,855.28. As the Committee has reported, from this point on, if the Public Relations program is carried out as planned, the program will probably cost from $18,000 to $20,000 a year, or approximately $1,500 per month. If the program is to be continued, the present annual dues of $20.00 per member will be needed to pay for it. We think it is worth while, and we recommend its continuance.

LIBRARY.—Our last report to this House of Delegates called attention to the establishment during the previous year of a motion picture lending service, the beginning of which was announced editorially in the October, 1943, number of the JOURNAL. Because of the war and the difficulty of securing materials necessary in the production of films, it has not been possible to develop the collection to the extent desired. In spite of this obstacle, we are pleased to report that, at the present time, the Library has forty-three 16 mm. films available for loan, 26 of which are sound and 17 silent. During the past year, 92 loans of films have been made to program committees of county medical societies, county medical society auxiliaries, nurses, premedical student groups, and high school and college groups. The films have been exhibited to 8,341 persons, the lay audience totaling 6,733 and the professional audience 1,608.

Of the 43 films available for lending, 19 have been placed in the Library on a long-term loan basis by pharmaceutical and biological firms, and 6 on the same basis by others interested in health education. The Library owns outright 18 films, of which number only 2 have been purchased.

Donors of films to the Library during the past year are: U. S. Public Health Service, *Magic Bullets*, a sound film on the discovery and benefits of "606," for lay audiences; and the Hurst Eye, Ear and Throat Hospital-Clinic, Longview, which purchased and donated the sound film, *Eyes for Tomorrow*, produced by the National Society for the Prevention of Blindness, which is also a splendid educational film for lay audiences on the conservation of vision.

Biologic and pharmaceutic organizations which have placed films in the Library on a long-term loan basis, for re-lending, are:

Mead Johnson & Company	11
Lederle Laboratories	5
E. R. Squibb & Sons	1
Johnson & Johnson	1

Other agencies which have placed films in the Library on a similar basis are:

British Information Services	1
National Foundation for Infantile Paralysis	1
American Social Hygiene Association	3
Texas State Department of Health	1

Appreciation is again expressed to the donors, and to all of the organizations which have made valuable contributions to the motion picture lending service, which we consider to have almost unlimited possibilities in visual education for both members of the medical profession and the lay public when films may again be secured as desired.

Reference should be made to the fact that special, confidential reviewing committees were appointed by the Trustees during the past year to pass upon films under consideration for purchase, or offered as donations, before they were accepted for the loan collection. The desirability of such procedure is apparent. No film should be made a part of our lending collection that is not creditable from an ethical and professional standpoint, since its lending by the Library places upon it, to some extent, the endorsement of the Association.

There are attached to this report as Exhibits "A" and "B," the printed lists of films in the Library, available for professional and lay audiences, with descriptions of each, which lists are readily avail-

able to any members of the Association or Auxiliary interested in the service. They may be secured from the Library on request.

Passing now to the Library package service rendered during the past year, we find that there have been almost exactly the same number of borrowers by mail, with an increase in the number of local users. The most significant feature noted in the package service, which is, of course, readily understood, is the increase in the number of medical officers from military stations throughout Texas who are using the service. They have more than compensated for the decrease in the use of the Library by physicians in civilian practice, occasioned by the depletion in the number of the latter, and their lack of time for such study.

Despite the difficulties almost universally experienced by all during the war, as far as we know, the Library service continued to meet with the approval of our members. If there were complaints, we have not heard them, and we should like to be informed, in order that any deficiencies may be corrected. The only comments received on the Library service have been commendatory.

In our last report we referred to the fact that the present building of the Association is inadequate for the needs of the Library, which should be housed in a modern, fireproof building; that we should plan to erect such a building as soon as possible after the war is over. We point again to this need in connection with the efforts that have been made by the Library Endowment Committee of the Association to secure funds. We commend that committee for its efforts, and especially for pointing out to county medical societies the needs of the Library if it is to continue to grow and render effective services. While only 10 of the 126 county medical societies have so far responded to that appeal, and donated only $400.00, the effort was worth while and has resulted in the beginning of a fund which might well be used for the construction of the contemplated building.

We are especially pleased to report that the Woman's Auxiliary has added support of the Library to its many worth-while projects. During the past year, that organization has established the Woman's Auxiliary Library Endowment Fund, which at present is composed of two separate funds of $1,000 each, both of which were obtained by a library committee of the Auxiliary, headed by Mrs. S. F. Harrington of Dallas. The first of these funds was established by the parents of Mrs. Harrington, Mr. and Mrs. G. A. Ray of Pettus, in memory of a daughter, and named for her; the other was established by the Presidents of the Woman's Auxiliary, from contributions made by all of the presidents who have served the Auxiliary, plus donations from husbands of these presidents. We are especially pleased to have the support of the Woman's Auxiliary in this connection. Whatever that organization determines to do, it does wholeheartedly and well.

We give here an account of the nine endowment funds of the Library, showing how the income from each is being used. We do this not only to give proper credit and honor to the donors, but to stimulate suggestions from members of the Association as to how these funds may be better expended. A report of the funds follows:

DR. AND MRS. SAM E. THOMPSON MEMORIAL FUND			$1,000.00
(Established by Dr. and Mrs. Sam E. Thompson, Kerrville, Texas, July 30, 1940).			
Dividend on Equitable Building and Loan Association		$30.00	
Balance from last year		8.22	
Total		$38.22	
Journal of General Physiology	$ 5.00		
Diseases of the Nervous System	2.50		
American Journal of Syphilis	6.75		
Journal of Thoracic Surgery	6.75		
Journal of Bacteriology	10.00		
American Review of Soviet Medicine	6.00		
Total		$37.00	
Balance Unexpended		$ 1.22	
WARNER E. WILLIAMS MEMORIAL FUND			$1,000.00
(Established by Dr. and Mrs. E. W. Bertner, Houston, Texas, July 30, 1940, in memory of Mrs. Bertner's father.)			
Dividend on Equitable Building and Loan Association		$30.00	
Balance from last year		4.44	
Total		$34.44	
Journal of Nervous and Mental Diseases	$10.00		
Medicine	5.00		
American Journal of Clinical Pathology	6.00		
Cancer Research	7.00		
Journal of Parasitology	5.00		
Total		$33.00	
Balance Unexpended		1.44	
TEXAS PEDIATRIC SOCIETY LIBRARY ENDOWMENT FUND			$1,000.00
(Established by the Texas Pediatric Society, July 30, 1940.)			
Dividend on Tarrant County Building and Loan Assn.		$30.00	
Balance from last year		66.54	
Total		$96.54	
Journal of Pediatrics	$ 8.50		
Total		$ 8.50	
Balance Unexpended		$88.04	
HATTIE PRESTON HUNT FUND			$1,000.00
(Established by Dr. Preston Hunt, Texarkana, Texas, May 22, 1941, in memory of Mrs. Hunt.)			
Interest on U. S. Government Bond, Series G		$25.00	
Balance from last year		7.25	
Total		$32.25	
Anesthesiology	$ 6.00		
International Surgical Digest	3.00		
British Journal of Urology	5.75		
American Journal of Anatomy	15.00		
American Journal of Medical Technology	2.50		
Total		$32.25	
DR. AND MRS. N. D. BUIE FUND			$1,000.00
(Established by Dr. and Mrs. N. D. Buie, Marlin, Texas, May 11, 1942.)			
Interest on U. S. Defense Bond, Series G		$25.00	
Balance from last year		1.87	
Total		$26.87	
Gastroenterology	$ 6.00		
Quarterly Review of Obstetrics and Gynecology	9.00		
Journal of Clinical Endocrinology	6.50		
Medical Woman's Journal	1.50		
Total		$23.00	
Balance Unexpended		3.87	
MR. AND MRS. WM. THOMAS CARTER FUND			$1,000.00
(Established by Dr. and Mrs. Judson L. Taylor, Houston Texas, May 7, 1943, in memory of Mrs. Taylor's parents.)			
Interest on U. S. Defense Bond, Series G		$25.00	
Balance from last year		6.00	
Total		$31.00	
American Journal of Psychology	$ 6.50		
Journal of Immunology	9.00		
Military Surgeon	4.00		
Journal of Aviation Medicine	5.00		
Bulletin of Johns Hopkins Hospital	6.00		
Total		$30.50	
Balance Unexpended		$ .50	

DR. MARTIN JUNIUS TAYLOR FUND (Established by Dr. and Mrs. Judson L. Taylor, Houston, Texas, May 7, 1943.)			$1,000.00
Interest on U. S. Defense Bond, Series G		$25.00	
Balance from last year		2.50	
Total		$27.50	
Occupational Therapy	$ 5.00		
Nature	15.00		
Journal of Genetics	7.50		
Total		$27.50	
THE WOMAN'S AUXILIARY LIBRARY ENDOWMENT FUND			
The Romayne Ray Memorial Fund (Established October 9, 1944.)			$1,000.00
Interest on U. S. Defense Bond, Series G		$12.50	
Journal of the National Cancer Institute	$ 2.00		
U. S. Naval Medical Bulletin	1.00		
British Journal of Tuberculosis	6.00		
Total		$ 9.00	
Balance Unexpended		$ 3.50	
THE PRESIDENT'S LIBRARY ENDOWMENT FUND (Established October 12, 1944.)			$1,000.00
Interest on U. S. Defense Bond, Series G		$12.50	
Quarterly Review of Medicine	$ 9.00		
Total		$ 9.00	
Balance Unexpended		$ 3.50	

May 19, 1945

Dr. S. E. Thompson, President,
Texas Memorial Medical
Library Association,
Kerrville, Texas.
Dear Sir:

We have examined the accounting records of the Texas Memorial Medical Library Association for the fiscal year from April 25, 1944 to April 30, 1945.

Statement of cash receipts and disbursements of said Association for the period reviewed is as follows:

Cash on Deposit—April 25, 1944		$ 96.82
Receipts:		
Woman's Auxiliary of State Medical Association for:		
The Romayne Ray Memorial Fund	$1,000.00	
The Presidents' Library Endowment Fund	1,000.00	
County Societies for Library Building Fund	385.00	
Income from Investments:		
Tarrant County Building & Loan Association (restricted to use for Pediatric purposes)	30.00	
Equitable and Mutual Building & Loan Associations	60.00	
U. S. Savings Bonds, Series "G"	125.00	2,600.00
		$2,696.82
Disbursements:		
Purchase of U. S. Savings Bonds, Series "G", as investments of The Romayne Ray Memorial Fund and The Presidents' Library Endowment Fund ($1,000.00 each)		2,000.00
Cash on Deposit—April April 30, 1945		$ 696.82

Assets and capital of the Association as of April 30, 1945, were as follows:

ASSETS

Cash on Deposit		$ 696.82
Investments:		
Shares of Building and Loan Association	$3,000.00	
U. S. Savings Bonds, Series "G"	6,000.00	9,000.00
		$9,696.82

CAPITAL

Dr. and Mrs. Sam E. Thompson Memorial Fund	$1,000.00
Warner E. Williams Memorial Fund	1,000.00
Texas Pediatric Society Library Endowment Fund	1,000.00
Hattie Hunt Memorial Fund	1,000.00
Dr. and Mrs. N. D. Buie Fund	1,000.00
Dr. Martin Junius Taylor Fund	1,000.00
Dr. and Mrs. Wm. Thomas Carter Memorial Fund	1,000.00
Woman's Auxiliary Library Endowment Fund	2,000.00
County Medical Societies' Library Building Fund	385.00
Undistributed Income	311.82
	$9,696.82

The terms of the above Funds provide that the income therefrom shall be applied for the use and benefit of libraries maintained and operated by the State Medical Association of Texas. Income from the Texas Pediatric Society Library Endowment Fund is further restricted to use in connection with Pediatric service.

Yours very truly,
McCAMMON, MORRIS, PICKENS & MAYHEW

Finally, we should like to acknowledge with appreciation the following books given to the Library by the family of the late Dr. John M. Furman, of Fort Worth, a valued member of our Association, lost by death during the past year: Noyes, *Modern Clinical Psychiatry*, 1934; Greenhill, *Obstetrics in General Practice*, 1941; Griffith and Mitchell, *The Diseases of Infants and Children*, 1933; Leavitt, *The Operations of Obstetrics*, 1919; Edgar, *The Practice of Obstetrics*, 1913; Berkeley and Bonney, *The Difficulties and Emergencies of Obstetric Practice*, 1913; Pardee, *Clinical Aspects of the Electrocardiogram*, 1933; McDowell, *Clinical Physiology*, 1927; Crummer, *Clinical Features of Heart Disease*, 1932; Thewlis, *Geriatrics*, 1919; Year Book of the following: *Eye, Ear, Nose and Throat*, 1943; *General Medicine*, 1943; *Urology*, 1943; *Pediatrics*, 1943; *Obstetrics and Gynecology*, 1943; *General Therapeutics*, 1943; *Dermatology and Syphilology*, 1943; and *Forcheimer's Therapeusis of Internal Diseases*, 5 volumes and Index, 1919.

ANNUAL MEETING.—The Annual Meeting for 1945 has been a perplexing problem with the Association, in view of war restrictions. The Executive Council made early application for permission to hold its regular Annual Meeting, but the request was denied because of the fact that anticipated attendance on the meeting would be well above that allowed, which was fifty from out of town. Permission to hold the Annual Meeting of the House of Delegates was also denied, and for the same reason. Immediately the problem of perpetuation of the Association and its beneficent work arose. Whether the organic laws of the Association provided any authority for any officer or group to carry on, had to be determined. The administrative office of the Association could find none, except in the provision of the Constitution that "The Board of Trustees

shall decide all questions not specifically delegated to other authorities," and that the Board "shall, in general, serve as a Board of Directors, within the meaning of the corporate laws of the State of Texas." Whether the Board of Directors of a corporation could set up a deliberative body in the corporation, particularly if the corporation operated under a constitution and by-laws such as controls the activities of the State Medical Association, had to be determined. Therefore, the general attorney of the Association was consulted by the State Secretary. He held that no such authority exists. The Board of Trustees has decided that, under the unusual circumstances brought about by war conditions, the Association should continue with its present administrative set-up, including the present officers, councils and committees, until a regular meeting of the House of Delegates can be held. In the meantime, the Trustees will continue to study the unusual problems presented by the war, for the best interests of the Association. The State Secretary was advised that he should continue to make preparations for the anticipated annual meeting of the House of Delegates, assemble reports of officers, councils and committees, and hold them for presentation at such a time, according to custom, any such reports being subject in the meantime to revision or supplement.

Membership.—The membership of the Association is of interest to the Board of Trustees because of the finances involved. For that reason, the Board has called the matter to the attention of the House of Delegates each year. Membership is of particular interest this year, since the regular membership dues of the Association have been raised from $9.00 to $20.00 per year, and military membership dues have been set at $1.00 per year (to cover Medical Defense). The need of more money, if the activities of the Association were to be prosecuted as had been contemplated by many of its members, was discussed in the last report of the Board. Suggested amendments to the By-Laws were included in the report. The State Secretary will discuss the matter of membership in his report, but it is well that the Board of Trustees do the same thing, from the angle of finance.

Last year, at the time the books were closed, April 24, there were 4,258 members, divided as follows: Regular members, 3,177; military members, 1,019; intern members, 14; honorary members, 44; and members emeritus, 4. Dues from the regular members ($9.00), amounted to $28,593.00, and dues from intern and honorary members ($4.00), amounted to $232.00, making a total of $28,825.00. Military members and members emeritus paid no dues.

This year, when the books were closed, April 30, the total membership was 4,333, divided as follows: Regular members, 3,234; military members, 1,031; intern members, 25; honorary members, 40; and members emeritus, 3. Dues from the regular members ($20.00), amounted to $64,680.00; dues from intern and honorary members, ($4.00), amounted to $260.00; and dues from military members ($1.00), amounted to $1,031.00, making a total of $65,971.00. Emeritus members pay no dues.

Therefore, and the Trustees are happy to be able to so report, there has not only been an increase in the income from dues ($37,146.00), but also an increase in membership (75). Whether the increase will build up during the year as it usually does, and in what ratio, remains to be seen. For the entire year of 1944, there were 4,685 members, as against 4,258 at the time the books were closed that year, which represents a gain of 427 members during the balance of the year. This gain in membership, including the five categories thereof, actually produced a gain in money of $2,578.00. It would be difficult indeed, to figure the financial gain from the same ratio of increase in membership this year, because of the variation in dues of each classification. But it is clear that any gain will be financially important.

Before presenting the report of the auditor, and such comments upon the financial affairs of the Association as the Trustees may have to make, it may be well to advise that a recommendation of President-Elect Dr. Cody, that the fiscal year of the Association be changed from May to May, as it is at the present time, to correspond with the Association year, which is the calendar year, January to January, has been approved by the Board of Trustees. Dr. Cody recommended that the change be made during his administration. It was his purpose to give the Board of Trustees sufficient time in which to consider the matter before taking action. The suggested change, while involving many complications and difficulties, will be put into effect as soon as possible, and in accordance with the suggestion of the President-Elect.

Auditor's Report, Fiscal Year 1944-1945.—The Auditor's Report is attached hereto and made a part of this report.

The Total Assets of the Association, it will be noted, amount to $137,284.41. Last year, our assets totaled $112,011.21. There is an increase, therefore, of $25,273.20. This increase reflects the difference between the dues of last year ($9.00) and the dues of this year ($20.00), as already mentioned in this report, plus a moderate increase in income from advertising. This money shows in our total assets, but has not been distributed to any of the Funds. This distribution will be made during the fiscal year beginning May 1.

Our Investment Accounts have suffered the war handicaps, in common with all other investment businesses, in that rates on investments have been reduced to very nearly the percentage allowed in government securities. Indeed, our securities are coming to be more and more of the government sort. Since the preparation of the Auditor's Report, for instance, an additional sum of $20,000.00 has been invested in the Series G, 2½ per cent Savings Bonds.

The Auditor calls attention to our investment in American Telephone and Telegraph Company, 3 per cent Temporary Debenture Bonds. These bonds were supposed to be exchangeable for other securities of the company, including common stock, the purchase of which the Trustees intended to make. There has been an interruption of the plans and purposes of the Telephone Company in this particular, and we are not permitted to make the conversion. We have held the bonds pending such an opportunity. However, it is the present intention of the Trustees to convert these securities into some presently paying investment, or into cash. Adjustment is under way at the present time.

As has been explained heretofore, the Association Fund has cared for every expense of the Association not definitely falling into some specific category. The necessity of continuing this policy has been greater during the period of the war than before. Our responsibilities have developed in unexpected quarters. The fund shows a deficit of $4,965.40. This deficit is wholly incident to the fact that the added income from increased dues had not been credited to this Fund, and will not be so credited until the fiscal year beginning May 1, 1945. It is well to remember in this connection, that only one-twelfth of the dues is earned each month. Our accounting is so arranged that should the Association cease business in any month, the balance could be returned to those who paid it in a few days' time.

The Journal Fund has made money. This Fund

depends upon two sources of income, namely, the subscription ($3.00) and the advertising income. It has been our policy all along to put back into the JOURNAL all of the money it earns, where circumstances and good business judgment will permit. The JOURNAL made a profit during the fiscal year, of $4,921.38. Some of this profit would have been put back into the fund had we been able to get all of the paper we needed.

A constant effort is being made to improve the JOURNAL, particularly in the matter of its content, but incidentally in appearance. We have not planned to waste any money in simply dressing the JOURNAL, but it seems well to continue to aspire to gentility. During the year, a very promising department has been added, an editorial section called "Current Editorial Comment," which first made its appearance in the November, 1944, number. It is intended that the editorials published in the new department shall discuss current items pertaining to the science, art and practice of medicine, in contradistinction to the heretofore all too prevalent discussions of the propaganda sort—that is, propaganda to our own members about their own affairs. The editorials used in this department will be secured from competent members of the Association throughout the State who are not directly connected with the management of the Association, or even with the JOURNAL. These editorials will be as brief as the subject matter discussed will permit, rarely exceeding 500 words in length.

It is well to remember in thinking of the JOURNAL income, that military members do not include subscription price to the JOURNAL ($3.00) in their dues, as is the case with other members. They pay only for Medical Defense ($1.00). Any military member can, of course, subscribe for the JOURNAL, at any time.

The Medical Defense Fund continues to show a healthy balance. There has not been as much demand on this Fund during the past year as is usually the case, but it must be remembered that those of our members who are with the Armed Forces are not exempt from medical malpractice damage suits, a fact which it is best not to publish too greatly. Insurance companies writing indemnity in this field have offered a special policy to cover this particular jeopardy.

The Public Relations Fund, it must be remembered, now covers a multiplicity of activities. We have had the Fund all along, but its ramifications have not been very extensive. During the past year a sufficient amount of credit was transferred from the Unappropriated Surplus to cover deficits incident to the operation of the Fund under the old order, and its opération after it assumed the responsibility for the expenditures of the Committee on Public Relations. A casual examination of the account of this Fund will disclose the bookkeeping transaction involved. The Fund actually shows a loss of $178.21, but it must be considered that here, as is the case with all other funds, the increment from the increased dues for the year will not be applied until the new fiscal year. It will be noted that the activities under this Fund have been divided into "Legislative Expense," and "Educational and Publicity" (largely of the Committee on Public Relations).

The preparation of a budget for the next fiscal year has been a most difficult task. It cannot be anticipated with any degree of accuracy just what demands will be made upon each of the funds, or any combination thereof. The increased dues have been allocated to these funds in such a manner as to allow for a surplus in each fund, with the expectation that proper adjustment as between the surplus of each fund and the Unappropriated Surplus will be made at the end of the year. By that time, particularly if conditions throughout the country have begun to approach the normal, it may be relatively easy to determine just how much money will be needed to maintain the desired and worth-while activities, which will lead to an easy enough determination as to the amount needed in each fund.

Particular attention is called to that part of the Auditor's Report pertaining to the Texas Memorial Medical Library Association. It will be remembered that the Library Association is a common law trust, to which contributions may be made with deductions from Income Tax accordingly. The members of the Board of Trustees constitute the Library Association. The money of the Library Association is held in trust for the purpose for which it has been donated, which it is expected will be only the support of the Library to the extent that its funds will allow. It is within the province of the Library Association to accept donations for the construction of a modern library building, and for the support of a complete Library for the State Medical Association. In no instance will the Library Association own or control any part of the State Medical Association or its Library.

The Auditor's Report, in full, follows:

AUDITOR'S REPORT

May 19, 1945

The Board of Trustees,
State Medical Association of Texas,
Fort Worth, Texas.
Gentlemen:

Pursuant to engagement we have audited the books of account of the State Medical Association of Texas for the period from April 25, 1944, to April 30, 1945, and submit herein our report containing the following statements and schedules:

Statement of Assets and Net Worth as of April 30, 1945.
Investments.
Analysis of Net Worth.
Condensed Summary of Income and Expense.
Income and Expense—Detailed (including comparison with budget).
Analysis of Expenses.
Proposed Budget for the year 1945-1946.

ASSETS AND NET WORTH

Supplementing the schedules submitted herein, we offer the following comments for your further information.

Investments, $64,446.26, as scheduled herein, were verified by correspondence with the State National Bank of Houston with respect to the Freeman and Culmore first mortgage notes held for collection by said bank, and by inspection of the other securities held in the Treasurer's safety deposit box at the Fort Worth National Bank. The following changes were effected in Investments during the past fiscal year:

Investments—April 25, 1944	$64,446.26
Additions:	
U. S. Savings Bonds, Series "G"	13,600.00
	$78,046.26
Sale at par of Home Owners Loan Corporation Series A 3% Bonds	13,600.00
Investments—April 30, 1945	$64,446.26

Interest and dividends were collected in the aggregate amount of $2,645.00, or 4.1% of the principal sum.

Your attention is directed to the footnote to the accompanying schedule covering Investments, stating that American Telephone & Telegraph Co. Temporary Debenture Bonds have not yet been exchanged in accordance with the provisions of said bonds.

Fixed Assets were increased by $702.04, consisting of additions to furniture, fixtures and office equipment, including six room coolers costing $450.00.

OPERATIONS

Income from all sources was received by the Association in the amount of $61,784.58, and expenses totaling $74,118.05 were incurred, resulting in a net loss of $12,333.47.

A comparative recapitulation of the membership for the past two years is as follows:

	Year Ended 1944	1943
Regular Members	3,455	3,469
Military Members	1,149	1,060
Interns	26	20
Honorary Members	51	54
Emeritus Members	4	4
	4,685	4,607

By action of the House of Delegates at the annual meeting in May, 1944, dues of regular members were increased from $9.00 to $20.00 per year, effective January 1, 1945. None of this increase is included in income for the year reviewed by this report, but dues which have been collected at the $20.00 rate are classified herein as "Unearned Dues" and will be treated as income for the ensuing fiscal year.

GENERAL

Fidelity bonds are carried on officers and employees of the Association as follows:

Dr. Holman Taylor, Secretary and Editor	$ 5,000.00
Dr. R. B. Anderson, Assistant Secretary-Editor	5,000.00
Dr. K. H. Beall, Treasurer	15,000.00
Miss Anna Keith, Bookkeeper	5,000.00

SCOPE OF AUDIT

In addition to the verification of assets described hereinbefore, we made routine substantiation of the regularity and accuracy of your records.

The recorded total of dues received was balanced against the membership roll. All receipts issued for payment of advertising accounts, income from investments, etc., were checked in detail against the cash receipts record. Items of income from investments were compared with description of the investments; and income from journal advertising was verified by test check of the advertising appearing in the publication against charges to the advertisers' accounts.

Checks paid by the depository banks during the period under review were inspected, compared with the corresponding entries in the disbursements record, and the recorded totals proved by addition. Paid invoices were examined when further substantiation of disbursements was considered advisable.

Postings to the general ledger were test-checked, and other tests were made of the correctness of your general records.

CONCLUSION

Our examination reflected that all recorded cash receipts were satisfactorily accounted for, and that the financial affairs of the Association were properly administered during the year reviewed.

We are submitting a separate report on the Texas Memorial Medical Library Association, formed in 1940 for the purpose of providing monies for the use and benefit of libraries maintained and operated by the State Medical Association of Texas.

In our opinion the accompanying statements, as disclosed by records examined, correctly reflect the financial condition of the State Medical Association of Texas as of April 30, 1945, and the results of operations for the fiscal year ended at that date.

Yours very truly,

McCammon, Morris, Pickens & Mayhew.

STATEMENT OF ASSETS AND NET WORTH

As of April 30, 1945

ASSETS

Cash on Hand and on Deposit		
On Hand—Secretary's Office	$ 80.00	
On Deposit—Secretary's Account	1,475.24	
On Deposit—Treasurer's Account	57,312.56	$ 58,867.80
Investments		
First Mortgage Loans	$24,500.00	
Stocks and Bonds—Cost	39,946.26	64,446.26
Other Assets		
Accounts Receivable—for Journal Advertising	$ 2,710.95	
Less: Credits for Prepaid Advertising	1,419.00	
	$ 1,291.95	
Less: Reserve for Uncollectible Accounts	100.00	
	$ 1,191.95	
Interest Receivable	112.50	1,304.45
Fixed Assets		
Real Estate—Land	$ 3,000.00	
Office Building	10,874.51	
Furniture and Fixtures	16,385.80	
	$30,260.31	
Less: Reserve for Depreciation	18,408.63	11,851.68
Deferred Expense		
Prepaid Insurance	$ 585.05	
Other Prepaid Expenses	221.17	
Utility Deposits	8.00	814.22
Total Assets		$137,284.41

RESERVES AND NET WORTH

Reserves		
Unearned Dues:		
Association Fund	$51,744.00	
Journal Fund	9,897.00	
Medical Defense Fund	4,330.00	
Unearned Journal Subscriptions—Non-Members	342.35	
Social Security and Withholding Tax	468.00	
Total Reserves		$ 66,781.35
Net Worth		
Association Fund	$11,149.20	
Journal Fund	19,203.74	
Medical Defense Fund	28,673.71	
Public Relations Fund	—178.21	
Unappropriated Surplus	11,654.62	
Net Worth		70,503.06
Total Reserves and Net Worth		$137,284.41

INVESTMENTS

As of April 30, 1945

	Amount of Investments	Income 4-24-'44 to 4-30-'45
Real Estate First Mortgage Loans		
John H. Freeman Notes:		
2 Notes—$3,500.00 each	$ 7,000.00	
Dated 5-15-42; due 5-15-45		
Interest—4% per annum, payable semi-annually		$ 280.00
1 Note	7,500.00	
Dated 11-1-43; due 11-1-47		
Interest—4% per annum, payable semi-annually		300.00
Above notes secured by first lien on property in Houston, Texas.		

March Culmore Note:		
1 Note	10,000.00	
Dated 6-6-43; due 6-6-48		
Interest—4½% per annum payable semi-annually		450.00
Secured by first lien on property in Houston, Texas.		
Total First Mortgage Loans	$24,500.00	$ 1,030.00
Stocks Owned		
Anaconda Copper Co.:		
86 Shares costing	$ 5,348.75	$ 215.00
Par Value $50.00 per share.		
American Telephone & Telegraph Co.:		
114 Shares—common—costing	14,489.71	1,026.00
Par Value $100.00 per share.		
Total Stocks Owned	$19,838.46	$ 1,241.00
Bonds Owned		
Home Owners Loan Corporation:		
Series "A" 3% Bonds—par $13,600.00 Sold 11-10-44.	$ ——	$ 204.00
*American Telephone & Telegraph Co.:		
$1,500.00 3% Temporary Debenture Bonds—Cost	1,507.80	45.00
United States Savings Bonds:		
Series "G", 2½%—maturity 1-1-1956	5,000.00	125.00
Series "G", 2½%—maturity 12-1-1956	13,600.00	
Total Bonds Owned	$20,107.80	$ 374.00
Total Stocks and Bonds	39,946.26	1,615.00
Total Investments	$64,446.26	$ 2,645.00

ANALYSIS OF NET WORTH

April 30, 1945

Association Fund			
Net Worth—April 25, 1944		$16,114.60	
Revenue—Current Year	$16,200.50		
Expense—Current Year	21,165.90	—4,965.40	
Net Worth—April 30, 1945			$ 11,149.20
Journal Fund			
Net Worth—April 25, 1944		$14,282.36	
Revenue—Current Year	$38,445.08		
Expense—Current Year	33,523.70	4,921.38	
Net Worth—April 30, 1945			19,203.74
Medical Defense Fund			
Net Worth—April 25, 1944		$27,313.09	
Revenue—Current Year	$ 3,532.00		
Expense—Current Year	2,171.38	1,360.62	
Net Worth—April 30, 1945			28,673.71
Public Relations Fund			
Net Worth—April 25, 1944		$ —223.48	
Transferred from Unappropriated Surplus—July 25, 1944		13,418.32	
Refund of Prior Year Expenses		277.02	
Revenue—Current Year	$ 3,607.00		
Expense—Current Year	17,257.07	—13,650.07	
Net Worth—April 30, 1945			—178.21
Special Appropriations Fund			
Net Worth—April 25, 1944		$25,072.94	
Transferred to Public Relations Surplus July 25, 1944		—13,418.32	
Net Worth—April 30, 1945			11,654.62
Total Net Worth—April 30, 1945			$70,503.06

CONDENSED SUMMARY OF INCOME AND EXPENSE

April 25, 1944 to April 30, 1945

Income			
Association Fund		$16,200.50	
Journal Fund		38,445.08	
Medical Defense Fund		3,532.00	
Public Relations Fund		3,607.00	
Total Income			$ 61,784.58
Expense			
Association Fund		$21,165.90	
Journal Fund		33,523.70	
Medical Defense Fund		2,171.38	
Public Relations Fund		17,257.07	
Total Expense			74,118.05
Net Loss			—$ 12,333.47
Net Income by Funds:			
Association Fund		—$ 4,965.40	
Journal Fund		4,921.38	
Medical Defense Fund		1,360.62	
Public Relations Fund		—13,650.07	
Net Loss		—$12,333.47	

*The above American Telephone & Telegraph Company 3% Temporary Debenture Bonds are exchangeable for either of the following:

(1) For $1,500.00 of 3% Definitive Debenture Bonds, without additional cash outlay; or

(2) For 15 shares of Common Stock of American Telephone & Telegraph Company, which conversion would require the cash payment by the Association of $600.00 ($40.00 per share).

The last interest coupon of the Temporary Debenture Bonds was dated September 1, 1942. Subsequent interest maturities have not been collected, but are set up herein as Interest Receivable. In order to collect such maturities of March 1, 1943, September 1, 1943, March 1, 1944, September 1, 1944 and March 1, 1945, it will be necessary to forward the bonds to the designated fiscal agent in New York for notation thereon of, and payment of, the interest.

INCOME AND EXPENSE

April 25, 1944 to April 30, 1945

	Actual	Budget	Over	Under
Association Fund				
Income:				
Membership Dues	$13,820.00	$13,200.00	$ 620.00	$
Interest and Dividends	2,380.50	2,880.00		$ 499.50
	$16,200.50	$16,080.00	$ 120.50	$
Expense:				
Annual Meeting	$ 2,293.39	$ 750.00	$ 1,543.39	$
Officers' Traveling, etc.	792.20	650.00	142.20	
Salaries	7,795.03	7,500.00	295.03	
Administration	3,549.62	2,500.00	1,049.62	
Library	6,686.53	4,500.00	2,186.53	
Procurement and Assignment	49.13	2,050.00		2,000.87
	$21,165.90	$17,950.00	$ 3,215.90	$
Net Income—Association Fund	—$ 4,965.40			
Journal Fund				
Income:				
Membership Dues	$10,596.00	$ 9,900.00	$ 696.00	$
Non-Membership Subscriptions	443.47	150.00	293.47	
Sale of Journals	43.89		43.89	
Advertising	27,097.22	20,000.00	7,097.22	
Interest and Dividends	264.50	320.00		55.50
	$38,445.08	$30,370.00	$ 8,075.08	$
Expense:				
Printing and Distribution	$17,632.49	$15,000.00	$ 2,632.49	$
Salaries	12,520.38	11,500.00	1,020.38	
Administration	3,370.83	2,450.00	920.83	
	$33,523.70	$28,950.00	$ 4,573.70	
Net Income—Journal Fund	$ 4,921.38			
Medical Defense Fund				
Income:				
Membership Dues	$ 3,532.00	$ 3,300.00	$ 232.00	$
	$ 3,532.00	$ 3,300.00	$ 232.00	$
Expense:				
Attorney Fees	$ 1,200.00	$ 1,200.00	$	$
Salaries	960.00	960.00		
Administration	11.38	40.00		28.62
	$ 2,171.38	$ 2,200.00		$ 28.62
Net Income—Medical Defense Fund	$ 1,360.62			
Public Relations Fund				
Income:				
Membership Dues	$ 3,455.00	$ 3,300.00	$ 155.00	$
Special Contributions	152.00		152.00	
	$ 3,607.00	$ 3,300.00	$ 307.00	$
Expense:				
Legislative and Educational	$12,116.21	$ 5,500.00	$ 6,616.21	$
Salaries	5,045.00	3,600.00	1,445.00	
Administration	95.86	85.00	10.86	
	$17,257.07	$ 9,185.00	$ 8,072.07	$
Net Income—Public Relations Fund	$—13,650.07			
Total Net Income	$—12,333.47			

ANALYSIS OF EXPENSE
April 25, 1944 to April 30, 1945

ASSOCIATION FUND

Annual Meeting Expense		
Meeting Places—Sections and General	$ 138.26	
General and Staff Expense	1,162.54	
Convention Literature and Badges	428.22	
Scientific Expense	353.67	
Guests Expense	193.00	
Insurance	17.70	$ 2,293.39
Officers' Expense		
Traveling, etc.		792.20
Salaries		
Secretary	$ 3,876.70	
Assistant Secretary	1,050.00	
Bookkeeper and Stenographers	2,868.33	7,795.03
Administration		
Journal Space	$ 224.00	
Stationery and Printing	210.64	
Postage	258.84	
Telephone and Telegraph	254.63	
General Expense	195.92	
Binding	24.00	
Heat	81.41	
Light and Water	124.81	
Janitor's Salary and Supplies	312.88	
Maintenance and Repair	726.01	
Collection and Exchange	.92	
Depreciation—Building	271.86	
Depreciation—Furniture and Fixtures	475.49	
Taxes—Property	5.90	
Taxes—Social Security	139.82	
Audit, Bonds and Insurance	210.56	
Insurance on Real Estate	31.93	3,549.62
Library Expense		
Salaries	$ 4,222.50	
Janitor Service	284.00	
Telephone and Telegraph	149.85	
Utilities	205.57	
Supplies	209.76	
Postage and Express	43.98	
Books and Publications	671.52	
Binding	622.90	
Audit and Insurance	207.98	
Taxes	5.80	
Miscellaneous	62.67	$ 6,686.53
Other Expense		
Procurement and Assignment		49.13
Total Expense—Association Fund		$ 21,165.90

JOURNAL FUND

Cost of Printing and Distribution		
Printing	$14,340.91	
Engraving	804.48	
Mailing and Delivery	441.00	
Commissions and Discount on Advertising	2,046.10	$ 17,632.49
Salaries		
Editor (Secretary)	$ 3,876.70	
Assistant Editor (Assistant Secretary)	4,783.40	
Bookkeeper and Stenographers	3,860.28	12,520.38
Administration		
Stationery and Printing	$ 234.15	
Telephone and Telegraph	145.94	
Office Postage	260.84	
Office Supplies and General Expense	305.37	
Heat	81.46	
Light and Water	124.90	
Janitor's Salary and Supplies	312.91	
Maintenance and Repair	726.03	
Depreciation—Building	271.86	
Depreciation—Furniture and Fixtures	475.49	
Taxes—Property	5.90	
Taxes—Social Security	178.50	
Auditor, Bonds and Insurance	215.56	
Insurance on Real Estate	31.92	$ 3,370.83
Total Expense—Journal Fund		$ 33,523.70

MEDICAL DEFENSE FUND

Attorney Fees		
Legal Services		$ 1,200.00
Salaries		
Secretary	$ 480.00	
Bookkeeper and Stenographer	480.00	960.00
Administration		
Taxes—Social Security		11.38
Total Expense—Medical Defense Fund		$ 2,171.38

PUBLIC RELATIONS FUND

Legislative and Educational		
Legislative Expense	$ 3,022.50	
Educational and Publicity (largely of Committee on Public Relations)	9,093.71	$ 12,116.21
Salaries		
Secretary	$ 600.00	
Director	3,500.00	
Stenographers	945.00	5,045.00
Administration		
Taxes—Social Security	$ 85.86	
Audit	10.00	95.86
Total Expense—Public Relations Fund		$ 17,257.07

PROPOSED BUDGET FOR FISCAL YEAR 1945-1946
BASED ON $20.00 DUES

Budget Appropriation	Income	Expense
Association Fund		
From Dues ($8.00 per member)	$27,200.00	
From Interest and Dividends	2,565.00	
To be applied to:		
Officers' Expense		$ 875.00
Salaries		8,500.00
Administration		3,825.00
Library		7,300.00
Procurement and Assignment		65.00
	$29,765.00	$ 20,565.00
Journal Fund		
From Dues ($3.00 per member)	$10,200.00	
From Interest and Dividends	285.00	
From Journal Advertising	25,000.00	
From Other Sources—Non-Members	400.00	
To be applied to:		
Cost of Printing and Distribution		$ 18,000.00
Salaries		13,000.00
Administration		4,000.00
	$35,885.00	$ 35,000.00
Medical Defense Fund		
From Dues of Regular Members ($1.00 per member)	$ 3,400.00	
From Dues of Military Members ($1.00 per member)	1,000.00	
To be applied to:		
Attorney Fees, etc.		$ 1,200.00
Salaries		960.00
Administration		40.00
	$ 4,400.00	$ 2,200.00
Public Relations Fund		
From Dues ($8.00 per member)	$27,200.00	
To be applied to:		
Legislative and Educational		$ 21,800.00
Salaries		5,300.00
Administration		100.00
	$27,200.00	$ 27,200.00
Total Estimated Income and Proposed Application	$97,250.00	$ 84,965.00
Estimated Income:		
Dues	$69,000.00	
Journal Advertising	25,000.00	
Interest and Dividends	2,850.00	
Other Sources—Non-Members	400.00	
	$97,250.00	

It is quite evident to all who have occasion to determine proper action of officers and groups comprising the State Medical Association, that there is need of a complete overhauling of both Constitution and By-Laws. The Board of Trustees therefore recommends that such revision be accomplished as expeditiously as possible, and that the President of the Association, the President-Elect and the Board of Trustees, be appointed to make such revision. Section 2, Article XV of the Constitution (page 7, January 1, 1941 edition), authorizes such revision upon a two-thirds majority vote of the House of Delegates at any annual session, provided notice that such revision will be made has been given at a preceding session, and that the proposed revision be published in the JOURNAL not later than approximately three months prior to the annual session in which the final vote thereon is to be taken. This

recommendation, if approved by the House of Delegates, may be considered such a prior notice.

It is the opinion of the Trustees that our Constitution and By-Laws should provide that no appointed or elected member of a council or committee of the Association shall serve in any given capacity for a period in excess of ten years.

It is also the opinion of the Board of Trustees that the present Committee on Tuberculosis should be made a standing committee, with overlapping, five-year terms of office.

The Trustees are further of the opinion that the By-Laws should be so amended as to require that Councilors be nominated in their respective Councilor Districts, under a suitable and consistent plan, with confirmation or election by the House of Delegates.

The Board would also recommend that county medical society legislative committees be set up on an overlapping term of office basis, so that a continuing policy may be inaugurated and maintained. This is done now in county medical societies, in the matter of boards of censors, and delegates to the State Medical Association.

Report of the Board of Trustees
Fiscal Year 1945-1946

In the nature of the case, the Board of Trustees must make a specific report covering each fiscal year. The above report, prepared for presentation, if permissible, to a meeting of the House of Delegates held November 13, 1945, will serve aptly and very largely to cover also the fiscal year of 1945-1946. With the exception of the Auditor's Report, this report will, therefore, be somewhat abbreviated.

There is no change in the matter of military membership. It is perhaps well, however, to call attention to the fact that military membership ceases with the discharge of such members from the Service. Presumably, their regular membership dues will then be due.

The Committee on Procurement and Assignment reports that it no longer functions as a governmental agency, the work having been taken over by the State Medical Association as such. The problem of replacement of former Medical Officers returing to civil practice is one for the State Association and county medical societies. Procurement and Assignment and replacement files will become the property of the State Medical Association, and the office of the State Secretary will direct activities in these particulars, perhaps through the newly appointed county medical society committees on hospital and medical service. The expense of this service will hereafter be covered by money appropriated by the Board of Trustees. These matters will be covered fully at this meeting, by the Report of the Committee on Procurement and Assignment.

The Public Relations Committee continues to operate under the direction of the Board of Trustees. According to the Report of the Auditor, published herewith, the extensive activities of the Committee have been rendered at a total cost of $22,997.25 for the fiscal year. As already reported, the office of the Committee is in the Central Office of the Association, at Fort Worth. The firm of Watson Associates, Dallas, has been employed as Public Relations Counsel, with a member of the firm (Mr. Philip E. Fox) assigned to serve the Public Relations Committee. The Trustees feel that the arrangements are about as convenient as they could well be under the circumstances. A study of the Auditor's Report will make it clear that if this service is to be continued, and expanded and improved upon, our membership dues must be continued at approximately their present level. The Trustees feel that the work should continue on its present, or increased tempo and extent.

The Library continues to serve the medical profession and the public quite satisfactorily, even though doctors have been entirely too busy trying to meet the demands made upon them to do a great deal of reading and research. Physicians in the Armed Forces have been in a state of transition, or at least expectation, for which reason they are not so extensively concerned with medical literature. However, the statistics disclose that Library Packages were more widely distributed during the present year than has ever been the case. Packages have been sent to a number of other states, to Texas physicians who remain with the Armed Forces. Physicians in other states have learned of the service from Medical Officers from Texas and have made use of it. Library Packages have even been mailed to Medical Officers overseas, in the several theaters of war.

Books and current literature have been sent to hospital libraries, medical college libraries, and camp libraries throughout the state.

The motion picture lending service, which was established in connection with the Library in October, 1943, has had a significant growth during the past year, and this in spite of the various shortages of materials necessary in the production of films and machines. Since the installation of this service, only two films have been purchased, the others having been gifts from individuals, or long-term loans from pharmaceutical and biological firms, and other agencies and organizations interested in health and medical education. As more funds become available for the Library, outstanding films will be purchased in addition to those available on loan from the sources named.

Despite all handicaps, we are pleased to report that the Library has sixty-four 16 mm. films available for loan, 42 of which are sound and 22 silent. This is an addition of 21 films during the past year. During this same period of time, 87 loans of films have been made to program committees of county medical societies and auxiliaries, hospital staffs, student nurses, premedical student groups, county and state health groups, high school and college groups, and army camps. The films have been exhibited to 7,721 persons, members of lay audiences totaling 5,853 and of professional audiences 1,868.

The following individuals and firms have placed films in the Library, some as outright gifts, and some on long-term loan basis: Dr. Louis Daily, Houston; Dr. Herbert Hipps, Marlin; Hurst Eye, Ear and Throat Hospital-Clinic, Longview; Mead Johnson & Company; Lederle Laboratories; E. R. Squibb & Sons; Johnson and Johnson; British Information Services; E. Fougera & Company, Inc.; Swift & Company; The Borden Company; Becton, Dickinson & Company; Winthrop Chemical Company; National Foundation for Infantile Paralysis; American Social Hygiene Association; Texas State Department of Health; Texas Tuberculosis Association, and United States Public Health Service. We wish to express our appreciation to all who have made these valuable contributions to the motion picture lending service. This comparatively new service has almost unlimited possibilities in visual education for members of the medical profession and the lay public when films are more readily available for loan and purchase.

From the beginning of this service, special confidential reviewing committees have been appointed by the Trustees to pass upon films under consideration for purchase or offered as donations or loans, before they are accepted for our files. This assures our collection of being creditable from an ethical and professional standpoint.

There are available in the Library at all times printed lists of these films, listing separately those suitable for lay and for professional audiences, with brief descriptive paragraphs of each. These lists may be secured from the Library upon request.

The Library Endowment Committee has suggested express on the films both ways, which amounts to very little. Borrowers are also held accountable for damage to films while in their possession, but since the establishment of this service in 1943, no borrower has had to pay for such damage.

The only charge made for our film service is the that the Committee be made a permanent, overlapping term-of-office committee. The Board of Trustees approves the idea, and approves a suggestion variously made that money now being rather generously contributed to the Texas Memorial Medical Library Association by individuals through county medical societies, and by county societies as a group, be set up as a "Building Fund." A total of $1,543.00 has already been raised through such contributions, as reported by the Committee.

A number of donations of literature needed by the Library have been made recently. Dr. Walter G. Stuck of San Antonio, has advised that his large and very comprehensive library of reprints on orthopedic surgery has been donated to the State Association Library. These have not yet been received and incorporated in the Library. A full account of this transaction will be rendered at another time.

The regular Library Endowment Funds already reported upon, have been augmented by the addition of the following:

INEZ ANTHONY HUDGINS ENDOWMENT FUND $1,000.00
(Represented by a United States Government Bond, Series F., contributed by Dr. D. H. Hudgins, Forney, Texas. This fund will be worth its face value in the course of twelve years.)

DR. STIRLING E. RUSS MEMORIAL FUND $1,000.00
(Represented by a United States Government Bond, Series F., contributed by Dr. W. B. Russ, San Antonio, Texas. This fund will be worth its face value in the course of twelve years.)

THE COUNTY MEDICAL SOCIETY LIBRARY BUILDING FUND $1,543.00
(Representing donations to the Library Building Fund by individuals through county medical societies, and by county societies as a group. This money has been raised through the past two fiscal years.)

April 29, 1946.

Dr. S. E. Thompson, President,
Texas Memorial Medical
Library Association,
Kerrville, Texas.
Dear Sir:

We have examined the accounting records of the Texas Memorial Medical Library Association for the fiscal year from May 1, 1945, to April 23, 1946.

Statement of cash receipts and disbursements of said Association for the period reviewed is as follows:

Cash on Deposit—May 1, 1945		$ 696.82
Receipts:		
Woman's Auxiliary of State Medical Association	$ 175.50	
County Societies for Library Building Fund	1,143.00	
Dr. V. R. Hurst for Longview Foundation Fund	100.00	
Income from Investments:		
Tarrant County Building & Loan Association, Fort Worth, (restricted to use for Pediatric purposes)	25.00	
Equitable and Mutual Building & Loan Associations, Fort Worth	50.00	
U. S. Savings Bonds, Series "G"	150.00	1,643.50
		$ 2,340.32
Disbursements:		
Remittance to State Medical Association of Texas, for the use and benefit of the library of said Association		434.56
Cash on Deposit, April 23, 1946		$ 1,905.76

Assets and Capital of the Association as of April 23, 1946, were as follows:

ASSETS

Cash on Deposit		$ 1,905.76
Investments:		
Shares of Building and Loan Associations	$3,000.00	
U. S. Savings Bonds, Series "G"	6,000.00	
U. S. Savings Bonds, Series "F"	1,480.00	10,480.00
		$ 12,385.76

CAPITAL

Dr. and Mrs. Sam E. Thompson Memorial Fund	$ 1,000.00
Warner E. Williams Memorial Fund	1,000.00
Texas Pediatric Society Library Endowment Fund	1,000.00
Hattie Hunt Memorial Fund	1,000.00
Dr. and Mrs. N. D. Buie Fund	1,000.00
Dr. Martin Junius Taylor Fund	1,000.00
Dr. and Mrs. Wm. Thomas Carter Memorial Fund	1,000.00
Woman's Auxiliary Library Endowment Fund	2,175.50
County Medical Societies Library Building Fund	1,528.00
Dr. D. H. Hudgins Memorial Fund	740.00
Dr. Stirling E. Russ Memorial Fund	740.00
Longview Foundation Fund	94.44
Undistributed Income	107.82
	$ 12,385.76

The terms of the above Funds provide that the income therefrom shall be applied for the use and benefit of libraries maintained and operated by the State Medical Association of Texas. Income from the Texas Pediatric Society Library Endowment Fund is further restricted to use in connection with Pediatric service.

Yours very truly,
McCAMMON, MORRIS, PICKENS & MAYHEW.

Membership.—The Board of Trustees is interested in the matter of membership not alone because it is an index to the growth and prosperity of the Association, but because of the finances involved. The State Secretary will report officially on the matter.

In the report covering the fiscal year 1944-1945, ending April 30, the total membership of the Association was 4,333. These figures were broken down as follows: Regular members, 3,234; military members, 1,031; intern members, 25; honorary members, 40, and members emeritus, 3. Dues from the

regular memberships ($20.00 per capita) amounted to $64,680.00; dues from intern and honorary memberships ($4.00 per capita) amounted to $260.00, and dues from military memberships ($1.00 per capita) amounted to $1,031.00, making a grand total of $65,971.00. This total, for that particular time under the increased dues is comparable to the total at the time the books were closed, April 24, 1944, the last under the $9.00 regular dues setup. The grand total then, was $28,825.00.

This year, at the time the books were closed, April 23, the total membership was 4,339, which is broken down as follows: Regular ($20.00), 4,034; Military ($1.00), 215; Honorary ($4.00), 42; Intern ($4.00), 45, and Emeritus (no dues), 3. In money, this means from Regular Membership, $80,680.00; from Honorary and Intern Memberships combined, $348.00, and from Military Membership, $215.00, a total of $81,243.00.

The membership last year showed 1,031 Military Members. Presumably 816 Military Members have become Regular Members. That would make a difference in cash income of $16,320.00. Quite probably the present Military Membership will be reduced rather rapidly now for a time. The same difference per capita will result. It will be remembered in this connection, that a Military Member loses his status as such, immediately that he is separated from Military Service. If he would remain a member, he must pay the Regular Membership dues, in which instance he is credited with the $1.00 he has already paid.

THE AUDITOR'S REPORT FOR THE FISCAL YEAR 1945-1946 is attached hereto and made a part of this Report:

The Total Assets of the Association, it will be noted, now amount to $174,789.53. That is $37,505.11 more than last year. The Net Worth of the Association this year is $90,911.23. This figure last year was $70,503.06. Our Net Worth, therefore, has increased $20,408.17. It will be understood, of course, that except for our permanent investments, these figures change as the fiscal year progresses.

Our Investment Accounts have continued to reap the war-time investment harvest. There have been little or no opportunities to invest our money in any except government bonds. During the year we have converted the American Telephone and Telegraph Company Debenture Bonds referred to in our preceding report, into Common Stock of the Telephone Company, par value $2,107.80. We have invested $20,000.00 in United States Savings Bonds, Series G., which pay 2½ per cent per annum, payable semi-annually. Three first mortgage loans, totaling $14,500.00, were collected during the year. Interest and Dividends collected during the year amounted to $3,147.37, an average of 4.46 per cent interest on money invested.

A brief analysis of the Auditor's Report may be helpful.

The Association Fund cares for all of the assets of the Association not set up in special funds. This Fund, therefore, is apt to vary widely in its balances from time to time during the year. At the time of the present audit, the net worth of this Fund was $20,174.80. Last year this Fund actually showed a deficit. At the time of the audit last year, it will be remembered, the dues had been increased but no income from the increased dues had been added to any of the funds. At the same time, expenditures from the fund continued on a constantly increasing basis because of constantly increasing activities. As a matter of fact, the expenditures from this Fund during the year were $20,811.03.

The Journal Fund for the fiscal year shows a balance of $24,728.49, as against $14,282.36 last year.

The Medical Defense Fund, the most stable Fund of all, had a balance of $28,673.71. This Fund shows a balance this year of $30,533.78.

The Public Relations Fund last year showed a deficit of $178.21. An $8.00 per capita sum was allocated to this Fund out of the new and increased dues. During the year the sum of $26,992.00 was accumulated and the sum of $22,997.25 was expended. There is, therefore, a balance of $3,994.75. It may be stated here that the Public Relations Committee was instructed to call for additional appropriations in case additional money were needed to carry on special and increased activities. The money thus made available has been allocated to other Funds for purposes of bookkeeping.

The Budget for the forthcoming year has been based on a continuation of the present membership dues. It has been estimated that the total income from this and other sources will amount to $114,930.00. Our estimate of expenditures for the year is $92,100.00. If this estimate holds true, there should be a total balance of $22,830.00 at the end of the next fiscal year. That should be approximately $5.00 per member. In this calculation, no considerable increase in the activities of the Association has been anticipated, and it will be remembered that the Public Relations Committee may at anytime be called upon for greatly increased activities. Except for this circumstance, the Trustees would be in a position to recommend a reduction in dues. Because of the uncertainty of the future in this respect, the Trustees cannot so recommend. The normal expenses of the Association have increased materially during the past three years, in keeping with the increased cost of living generally.

The Trustees would have the members of the Association throughout give special attention to that part of the Auditor's Report having to do with the Texas Memorial Medical Library Association, and the services the Library is rendering the medical profession of this State. The Library of the Association is rendering a service of great importance, and would be in a position to greatly increase the value of its services were it properly housed, properly equipped and properly staffed. There should be a permanent Building Fund, aside and apart from money intended for the support of the Library, and it is recommended that money donated by individuals through county medical societies be set up as such a Fund.

The Auditor's Report in full, follows:

AUDITOR'S REPORT

April 29, 1946.

The Board of Trustees,
State Medical Association of Texas,
Fort Worth, Texas.
Gentlemen:

Pursuant to engagement we have audited the books of account of the State Medical Association of Texas for the period from May 1, 1945, to April 23, 1946, and submit herein our report containing the following statements and schedules:

Statement of Assets and Net Worth as of April 23, 1946.
Investments.
Analysis of Net Worth.
Condensed Summary of Income and Expense.
Income and Expense—Detailed (including comparison with budget).
Analysis of Expense.
Proposed Budget for the year 1946-1947.

ASSETS AND NET WORTH

Supplementing the schedules submitted herein, we offer the following comments for your further information.

Investments, $70,546.26, as scheduled herein, were verified by correspondence with the State National Bank of Houston with respect to the Culmore first mortgage note held for collection by said bank, and by inspection of the other securities held in the Treasurer's safety deposit box at the Fort Worth National Bank. The following changes were effected in Investments during the past fiscal year:

Investments—May 1, 1945		$ 64,446.26
Additions:		
15 Shares American Telephone & Telegraph Co. stock—common—Par Value $100.00 per share		2,107.80
U. S. Savings Bonds, Series "G"		20,000.00
		$ 86,554.06
Reductions:		
American Telephone & Telegraph Co. 3% Temporary Debenture Bonds, exchanged for Common Stock shown above	$ 1,507.80	
Principal Payments—John H. Freeman notes	14,500.00	16,007.80
Investments, April 23, 1946		$ 70,546.26

The exchange of $1,500.00 American Telephone & Telegraph Company debenture bonds for 15 shares of common stock of said company was made upon payment of $40.00 per share ($600.00).

Interest and dividends were collected in the aggregate amount of $3,147.37, or 4.46% of the principal sum.

Fixed Assets were increased by $1,067.82, consisting of additions to furniture, fixtures and office equipment.

OPERATIONS

Income from all sources was received by the Association in the amount of $103,371.80, and expenses totaling $83,030.63 were incurred, resulting in a net income of $20,341.17.

A comparative recapitulation of the membership for the past two years is as follows:

	For Year 1945	1944
Regular Members	3,374	3,455
Military Members	1,142	1,149
Interns	36	26
Honorary Members	59	51
Emeritus Members	3	4
	4,614	4,685

The membership period, for which dues are paid, is the calendar year.

GENERAL

Fidelity bonds are carried on officers and employees of the Association as follows:

Dr. Holman Taylor, Secretary and Editor	$ 5,000.00
Dr. R. B. Anderson, Assistant Secretary-Editor	5,000.00
Dr. K. H. Beall, Treasurer	15,000.00
Miss Anna Keith, Bookkeeper	5,000.00

SCOPE OF AUDIT

In addition to the verification of assets described hereinbefore, we made routine substantiation of the regularity and accuracy of your records.

The recorded total of dues received was balanced against the membership roll. All receipts issued for payment of advertising accounts, income from investments, etc., were checked in detail against the cash receipts record. Items of income from investments were compared with description of the investments; and income from JOURNAL advertising was verified by test check of the advertising appearing in the publication against charges to the advertisers' accounts.

Checks paid by the depository banks during the period under review were inspected, compared with the corresponding entries in the disbursements record, and the recorded totals proved by addition. Paid invoices were examined when further substantiation of disbursements was considered advisable.

Postings to the general ledger were test-checked, and other tests were made of the correctness of your general records.

CONCLUSION

Our examination reflected that all recorded cash receipts were satisfactorily accounted for, and that the financial affairs of the Association were properly administered during the period reviewed.

We are submitting a separate report on the Texas Memorial Medical Library Association, formed in 1940 for the purpose of providing monies for the use and benefit of libraries maintained and operated by the State Medical Association of Texas.

In our opinion the accompanying statements, as disclosed by records examined, correctly reflect the financial condition of the State Medical Association of Texas as of April 23, 1946, and the results of operations for the fiscal year ended at that date.

Yours very truly,

McCAMMON, MORRIS, PICKENS & MAYHEW.

STATEMENT OF ASSETS AND NET WORTH

As of April 23, 1946

ASSETS

Cash on Hand and On Deposit		
On Hand—Secretary's Office	$ 80.00	
On Deposit—Secretary's Account	8,590.61	
On Deposit—Treasurer's Account	82,878.97	$ 91,549.58
Investments		
First Mortgage Loans	$ 10,000.00	
Stocks and Bonds—Cost	60,546.26	70,546.26
Other Assets		
Accounts Receivable for Journal Advertising	$ 2,894.44	
Less: Credits for Prepaid Advertising	1,734.00	
	$ 1,160.44	
Less: Reserve for Uncollectable Accounts	100.00	1,060.44
Fixed Assets		
Real Estate—Land	$ 3,000.00	
Office Building	10,874.51	
Furniture and Fixtures	17,453.62	
	$ 31,328.13	
Less: Reserve for Depreciation	19,967.53	11,360.60
Deferred Expense		
Prepaid Insurance	$ 264.65	
Utility Deposits	8.00	272.60
Total Assets		$174,789.53

RESERVES AND NET WORTH

Reserves and Deferred Income		
Unearned Dues:		
Association Fund	$ 32,272.00	
Journal Fund	12,363.00	
Medical Defense Fund	4,336.00	
Public Relations Fund	32,272.00	
Unearned Journal Subscriptions—Non-Members	162.92	
Social Security and Withholding Taxes	442.06	
Deferred Income—1946 Annual Meeting	2,030.32	$ 83,878.30

Net Worth		
Association Fund	$ 20,174.80	
Journal Fund	24,728.49	
Medical Defense Fund	30,533.78	
Public Relations Fund	3,819.54	
Unappropriated Surplus	11,654.62	
Net Worth		90,911.23
Total Reserves and Net Worth		$174,789.53

INVESTMENTS

As of April 23, 1946

	Amount of Investment	Income 5-1-45 to 4-23-46
Real Estate First Mortgage Loans		
March Culmore Note:	$ 10,000.00	
Dated 6-6-43; Due 6-6-48		
Interest—4½% per annum, payable semi-annually		$ 450.00
Secured by first lien on property in Houston, Texas.		
John H. Freeman Notes:		
2 Notes—$3,500.00 each		
Dated 5-15-42; due 5-15-45		
Paid in full 5-15-45.		
Interest—4% per annum, payable semi-annually		140.00
1 Note—$7,500.00		
Dated 11-1-43; due 11-1-47		
Paid in full 3-15-46.		
Interest—4% per annum, and 1% principal prepayment penalty		487.50
Above notes were secured by first lien on property in Houston, Texas.		
Total First Mortgage Loans	$ 10,000.00	$ 1,077.50
Stocks Owned		
Anaconda Copper Co.:		
86 shares costing	$ 5,348.75	$ 215.00
Par Value $50.00 per share.		
American Telephone & Telegraph Co.:		
129 shares—common—costing	16,597.51	1,127.25
Par Value $100.00 per share.		
Total Stocks Owned	$ 21,946.26	$ 1,342.25
Bonds Owned		
*American Telephone & Telegraph Co.: $1,500.00 3% Temporary Debenture Bonds—Cost $1,507.80	$	$ 12.62
United States Savings Bonds:		
Series "G", 2½%—maturity 1-1-1956	5,000.00	125.00
Series "G", 2½%—maturity 12-1-1956	13,600.00	340.00
Series "G", 2½%—maturity 5-1-1957	20,000.00	250.00
Total Bonds Owned	$ 38,600.00	$ 727.62
Total Stocks and Bonds	60,546.26	2,069.87
Total Investments	$ 70,546.26	$ 3,147.37

ANALYSIS OF NET WORTH

April 23, 1946

Association Fund			
Net Worth—May 1, 1945		$ 11,149.20	
Additional Dues Collected—Prior Years		12.00	
Revenue—Current Year	$29,824.63		
Expense—Current Year	20,811.03	9,013.60	
Net Worth — April 23, 1946			$ 20,174.80
Journal Fund			
Net Worth—May 1, 1945		$ 19,203.74	
Additional Dues Collected—Prior Years		9.00	
Bad Debts Collected		40.00	
Revenue—Current Year	$41,944.17		
Expense—Current Year	36,468.42	5,475.75	
Net Worth — April 23, 1946			24,728.49
Medical Defense Fund			
Net Worth—May 1, 1945		$ 28,673.71	
Additional Dues Collected—Prior Years		3.00	
Revenue—Current Year	$ 4,611.00		
Expense—Current Year	2,753.93	1,857.07	
Net Worth — April 23, 1946			30,533.78
Public Relations Fund			
Net Worth—May 1, 1945		$ —178.21	
Additional Dues Collected—Prior Years		3.00	
Revenue—Current year	$26,992.00		
Expense—Current Year	22,997.25	3,994.75	
Net Worth — April 23, 1946			3,819.54
Special Appropriations Fund (No transactions from May 1, 1945, to April 23, 1946.)			
Net Worth — April 23, 1946			11,654.62
Total Net Worth — April 23, 1946			$ 90,911.23

*The above American Telephone & Telegraph Company 3% Temporary Debenture Bonds were exchanged July 5, 1945, for 15 shares of Common Stock of the same company, which conversion required the cash payment by the Association of $600.00 ($40.00 per share).

CONDENSED SUMMARY OF INCOME AND EXPENSE

MAY 1, 1945, TO APRIL 23, 1946

Income		
Association Fund	$ 29,824.63	
Journal Fund	41,944.17	
Medical Defense Fund	4,611.00	
Public Relations Fund	26,992.00	
Total Income		$103,371.80
Expense		
Association Fund	$ 20,811.03	
Journal Fund	36,468.42	
Medical Defense Fund	2,753.93	
Public Relations Fund	22,997.25	
Total Expense		83,030.63
Total Net Income		$ 20,341.17
Net Income by Funds:		
Association Fund	$ 9,013.60	
Journal Fund	5,475.75	
Medical Defense Fund	1,857.07	
Public Relations Fund	3,994.75	
Total Net Income	$ 20,341.17	

INCOME AND EXPENSE

May 1, 1945, to April 23, 1946

	Actual	Budget	Over	Under
Association Fund				
Income:				
Membership Dues	$26,992.00	$27,200.00	$	$ 208.00
Interest Earned	2,832.63	2,565.00	267.63	
	$29,824.63	$29,765.00	$ 59.63	$
Expense:				
Annual Meeting	$ 466.55	$	$ 466.55	$
Officers' Traveling, etc.	865.32	875.00		9.68
Salaries	8,785.00	8,500.00	285.00	
Administration	3,160.76	3,825.00		664.24
Library	7,533.40	7,300.00	233.40	
Procurement and Assignment		65.00		65.00
	$20,811.03	$20,565.00	$ 246.03	
Net Income—Association Fund	$ 9,013.60			
Journal Fund				
Income:				
Membership Dues	$10,407.00	$10,200.00	$ 207.00	$
Non-Membership Subscriptions	501.38	400.00	101.38	
Sale of Journals	82.15		82.15	
Advertising	30,638.90	25,000.00	5,638.90	
Interest and Dividends	314.74	285.00	29.74	
	$41,944.17	$35,885.00	$ 6,059.17	$
Expense:				
Printing and Distribution	$19,758.48	$18,000.00	$ 1,758.48	$
Salaries	13,988.75	13,000.00	988.75	
Administration	2,721.19	4,000.00		1,278.81
	$36,468.42	$35,000.00	$ 1,468.42	$
Net Income—Journal Fund	$ 5,475.75			
Medical Defense Fund				
Income:				
Membership Dues	$ 4,611.00	$ 4,400.00	$ 211.00	$
Expense:				
Attorney Fees	$ 1,760.00	$ 1,200.00	$ 560.00	$
Salaries	960.00	960.00		
Administration	33.93	40.00		6.07
	$ 2,753.93	$ 2,200.00	$ 553.93	$
Net Income—Medical Defense Fund	$ 1,857.07			

Public Relations Fund				
Income:				
Membership Dues	$26,992.00	$27,200.00	$	$ 208.00
Expense:				
Legislative and Educational	$16,543.14	$21,800.00	$	$ 5,256.86
Salaries	6,312.66	5,300.00	1,012.66	
Administration	141.45	100.00	41.45	
	$22,997.25	$27,200.00	$	$ 4,202.75
Net Income—Public Relations Fund	$ 3,994.75			
Total Net Income	$20,341.17			

ANALYSIS OF EXPENSE

May 1, 1945, to April 23, 1946

ASSOCIATION FUND

Annual Meeting Expense		
Meeting Places—Sections and General	$ 5.38	
General and Staff Expense	273.59	
Convention Literature and Badges	41.50	
Scientific Expense	96.69	
Technical Exhibits	31.69	
Insurance	17.70	$ 466.55
Officers' Expense		
Traveling, etc.		865.32
Salaries		
Secretary	$ 4,060.00	
Assistant Secretary	1,200.00	
Bookkeeper and Stenographers	3,525.00	8,785.00
Administration		
Journal Space	$ 224.00	
Stationery and Printing	218.90	
Postage	276.75	
Telephone and Telegraph	296.74	
General Expense	180.26	
Binding	24.00	
Heat	84.85	
Light and Water	153.41	
Janitor's Salary and Supplies	343.90	
Maintenance and Repairs	149.16	
Collection and Exchange	.92	
Depreciation—Building	271.86	
Depreciation—Furniture and Fixtures	507.59	
Taxes—Property	6.64	
Taxes—Social Security	177.23	
Audit, Bonds and Insurance	244.55	$ 3,160.76
Library Expense		
Salaries	$ 5,493.10	
Janitor Service	310.00	
Telephone and Telegraph	118.45	
Utilities	238.02	
Supplies	131.07	
Postage and Express	48.48	
Books and Publications	409.20	
Printing and Binding	431.65	
Audit and Insurance	222.63	
Taxes	6.27	
Repairs	76.43	
Dues	5.00	
Miscellaneous	43.10	$ 7,533.40
Total Expense—Association Fund		$ 20,811.03

JOURNAL FUND

Cost of Printing and Distribution		
Printing	$ 16,608.16	
Engraving	782.50	
Mailing and Delivery	469.00	
Commissions and Discounts on Advertising	1,898.82	$ 19,758.48
Salaries		
Editor (Secretary)	$ 4,060.00	
Assistant Editor (Assistant Secretary)	4,400.00	
Bookkeeper and Stenographers	5,528.75	$ 13,988.75
Administration		
Stationery and Printing	$ 140.97	
Telephone and Telegraph	142.86	
Office Postage	226.25	
Office Supplies and General Expense	277.08	
Heat	84.84	
Light and Water	153.36	
Janitor's Salary and Supplies	343.88	
Maintenance and Repair	149.14	
Depreciation—Building	271.86	
Depreciation—Furniture and Fixtures	507.59	
Taxes—Property	6.27	
Taxes—Social Security	202.54	
Audit, Bonds and Insurance	214.55	2,721.19
Total Expense—Journal Fund		$ 36,468.42

MEDICAL DEFENSE FUND

Attorney Fees		
Legal Services		$ 1,760.00
Salaries		
Secretary	$ 480.00	
Bookkeeper and Stenographer	480.00	960.00
Administration		
General Expense	$ 23.80	
Taxes—Social Security	10.13	33.93
Total Expense—Medical Defense Fund		$ 2,753.93

PUBLIC RELATIONS FUND

Legislative and Educational			
Legislative Expense		$ 1,523.49	
Committee on Public Relations:			
Public Relations Counsel	$ 6,454.71		
Salary—Stenographer	1,950.00		
Postage and Express	820.75		
Stationery and Printing	3,167.50		
Telephone and Telegraph	382.44		
Officers' Travel, etc.	1,113.00		
Broadcasting	797.72		
Sundry Expenses	333.53	$ 15,019.65	$ 16,543.14
Salaries			
Secretary		$ 400.00	
Assistant Secretary		400.00	
Director		3,600.00	
Stenographers		1,912.66	6,312.66
Administration			
Taxes—Social Security		$ 116.45	
Audit		25.00	141.45
Total Expense — Public Relations Fund			$ 22,997.25

PROPOSED BUDGET FOR FISCAL YEAR 1946-1947

Based on $20.00 Dues

Budget Appropriation	Income	Expense
Association Fund		
From Dues ($8.00 per member)	$ 32,400.00	
From Interest and Dividends	2,520.00	
To be applied to:		
Annual Meeting Expense		$ 3,500.00
Officers' Expense		875.00
Salaries		8,825.00
Administration		3,500.00
Library		8,000.00
	$ 34,920.00	$ 24,700.00
Journal Fund		
From Dues ($3.00 per member)	$ 12,420.00	
From Interest and Dividends	280.00	
From Journal Advertising	30,000.00	
From Other Sources—non-members	520.00	
To be applied to:		
Cost of Printing and Distribution		$ 20,000.00
Salaries		13,500.00
Administration		3,500.00
	$ 43,220.00	$ 37,000,00
Medical Defense Fund		
From Dues ($1.00 per member)	$ 4,390.00	
To be applied to:		
Attorney Fees, etc.		$ 1,800.00
Salaries		960.00
Administration		40.00
	$ 4,390.00	$ 2,800.00
Public Relations Fund		
From Dues ($8.00 per member)	$ 32,400.00	
To be applied to:		
Legislative and Educational		$ 20,000.00
Salaries		7,400.00
Administration		200.00
	$ 32,400.00	$ 27,600.00
Total Estimated Income and Proposed Application	$114,930.00	$ 92,100.00

Estimated Income:	
Dues	$ 81,610.00
Journal Advertising	30,000.00
Interest and Dividends	2,800.00
Other Sources—Non-Members	520.00
	$114,930.00

Estimated Membership:		
Regular—at	$20.00	4,050
Military—at	$ 1.00	250
Interns and Honorary—at	$ 4.00	90

This Report is closed with an expression of deep gratitude to the staff of the Central Office, and to many of our members who have been helpful to us in many ways. The illness of Dr. Anderson, Assistant Secretary-Editor, has resulted in a special strain on all concerned, but he, in spite of his illness, has been able to render considerable assistance in much of the work for which the Board of Trustees is responsible.

Respectfully submitted,

S. E. Thompson, Chairman,
E. W. Bertner, Vice-Chairman,
T. C. Terrell, Secretary,
W. B. Russ,
J. B. McKnight.

President Connally: The report of the Board of Trustees, including the auditor's report, is referred to the Reference Committee on Finance, except (a) that part referring to the Public Relations Committee, referred to the Reference Committee on Medical Service and Public Relations; and (b) that part referring to Amendments to the Constitution and By-Laws, referred to the Reference Committee on Amendments to the Constitution and By-Laws.

We will have the report of the Board of Councilors.

Dr. C. E. Scull, of San Antonio, Chairman, then presented the report of the Board of Councilors, as follows:

REPORT OF BOARD OF COUNCILORS

Written reports have been received from most of our Councilors, and all report that the war has hampered the activities of their county societies and state that the doctors who were left at home have not had time to do anything but work.

The Board of Councilors has met several times during the past two years to discuss various problems, but as a whole the Council has been inactive except for the routine work. There has been more or less activity against the Wagner-Murray-Dingell bill.

There was a called meeting of the Council at Fort Worth on September 9, 1945, to review the case of the Nueces County Medical Society, in which the Council upheld the action of the Nueces County Medical Society; however, this was appealed to the American Medical Association and is still on appeal.

All the Councilors report that many of their members are returning from the Armed Services, and the various county societies are more active, with plans for more activity in the future. We expect all the local medical societies, with the "new blood" of the younger doctors returning from service to take a new lease on life and enter the fight more vigorously to keep organized medicine on the high plane where it has always been.

Respectfully submitted,

C. E. Scull, Chairman,
R. T. Wilson, Secretary.

President Connally: The report of the Board of Councilors will be referred to the Reference Committee on Reports of Officers and Committees.

The report of the Council on Medical Defense.

Dr. W. D. Jones, of Dallas, Chairman, then presented the report of the Council on Medical Defense, as follows:

REPORT OF THE COUNCIL ON MEDICAL DEFENSE

It is difficult to combine two reports of the Council on Medical Defense, each covering the period of one year, as should be the case with this report, mainly because of the part statistics figures in each report. Therefore, we are dividing the report into two parts as follows. They would be normally the Thirty-First and Thirty-Second Annual Reports:

April, 1944, to April, 1945

No suits were disposed of during the period covered by this report. Three cases have been dropped for lack of information for the past five years. We carry these cases in our files only until cause for action is barred by statute of limitation. There were twelve cases pending at the time this report was due to be made. Five suits were threatened. Perhaps a tabulation will meet the requirements of the report:

Cases reported active April 1, 1944		12
Cases filed since that time		3
Total		15
Suits disposed of since 1943	0	
Suits dropped because no information received for five years	3	
Total	3	3
Suits carried as active and pending		12

Threatened suits carried in report of April 1, 1943	7
Suits threatened since said report	1
Total	8
Dropped because no information received for five years	3
Threatened suits now carried	5

It does not seem advisable to discuss the causes and character of malpractice damage suits filed against doctors. This Council has contended throughout its existence that very few malpractice damage suits have any merit at all. It may be looked upon as unfortunate that the practice of medicine is of such nature as to lend itself to claims under medical malpractice damage suits. Fortunately, the law covering the matter is so worded that except for a few types of cases, it is very difficult to convict a physician of medical malpractice if he has been careful, and has rendered service on a par with that rendered as a whole by the medical profession of his community.

The period of time covered by this report found many of our members in the medical service of our Armed Forces. We have called attention to the matter heretofore, but it remains a fact that not all of our members realize that a Medical Officer with the Armed Forces is not entirely free from the jeopardy of medical malpractice damage suits.

April, 1945, to April, 1946

At the beginning of the previous year, it will be noted above, there were twelve active malpractice damage suits pending. Since that time four new cases have been filed, making a total of sixteen on April 1 of this year. During the year, one case was disposed of, and three cases dropped because of lack of information about them for the usual five year period of time. That left a total of twelve cases to be carried over, which would make it appear that the affairs of the Council on Medical Defense are running almost routinely. These figures may be expressed in the following table:

Cases reported active in report of April 1, 1945	12
New cases filed since last report	4
Total	16

Suits disposed of since 1945 report	1	
Dropped because no information received for five years	3	
Total	4	4
Suits now carried as active and pending		12
Threatened suits carried in report of April 1, 1945	5	
Suits threatened since said report	0	
Total	5	
Dropped because no information received for five years	3	
Threatened suits now carried	2	

While the war has not officially closed, our members who have entered the Armed Forces are returning to civilian practice quite rapidly. They are bringing with them their medical malpractice jeopardy, which we hope will be practically *nil*, but which at the same time we know exists. Most of these have been what is called "Military Members," for which membership a fee of $1.00 annually is charged, to cover Medical Defense. Many of these members have been protected by malpractice damage suit policies issued by commercial companies. It is hoped that between the two, most of our members will be protected. We stand ready to help wherever needed, and where we are permitted to help under the terms of the By-Laws of the State Medical Association.

The finances of the Council on Medical Defense are reported upon each year by the Board of Trustees of the Association. The Council on Medical Defense alone can direct the expenditure of this money, but the Trustees of the Association have it in charge, and are authorized to invest it, along with other moneys of the Association. There is a relatively healthy reserve in the Medical Defense Fund, but not too much. There has been an accumulation during the past two years which is quite satisfactory, but in only such amount as might easily be wiped out by the filing of a few damage suits. It is understood by our members, we are sure, that the Council on Medical Defense cannot insure against loss in any damage suit. Indeed, it cannot enter the picture at all as an insurance proposition. It can do no more than make contributions in money to those of our members who are sued, and who do not have adequate protection through insurance.

We would close our report by the oft-repeated admonition that practicing physicians should carry indemnity insurance, and that the less talk there is about the patients of their fellow physicians, the less jeopardy of medical malpractice damage suits.

Respectfully submitted,
W. D. Jones, Chairman,
A. P. Howard,
W. L. Baugh,
W. A. King.

President Connally: The report will be referred to the Reference Committee on Medical Service and Public Relations.

Next, the report of the Executive Council.

Secretary Taylor then read the report of the Executive Council.

REPORT OF EXECUTIVE COUNCIL

This report will, of necessity, cover a period of two years. It is deemed best in the interest of clarity and conservation of time and paper to make one rather than two separate reports.

The last report of the Executive Council was submitted to the House of Delegates at the 1944 annual meeting at Dallas, May 10 and 11. It will be found in the June, 1944, number of the Texas State Journal of Medicine. Action taken on the report will be found in the Report of the Reference Committee on Reports of Officers and Committees, beginning on page 104 of the same number of the Journal. It will there be noted that the following mandates to the Executive Council were thus made:

"(1) That the Council be directed to continue the policy of the Association at present in force as relates to coöperation with organizations and groups interested in public health and welfare, including governmental agencies, and refraining from coöperation with any such which fail to recognize the proper place of the medical profession in connection with such matters, and under a realistic interpretation of the term 'coöperation,' in contradistinction to 'obedience.'

"(2) That the Council continue to oppose movements leading to the socialization of medicine through whatsoever procedures, always in consideration of the proper demands of war service and along the lines of the resolution on the subject herein recited, and after the plans at the present time in effect, with such modification or elaboration as the Council or other authoritative and appropriate agencies may see fit to make.

"(3) That the Council continue its unreserved coöperation in the war effort, making due distinction between real war effort and pseudo war effort.

"(4) That the Council continue in support of the Committee on Medical Licensure in its plans for medical legislation, with the understanding that no controversial legislation of the sort be undertaken at the present time, except under emergency situations which may arise and which may jeopardize the interests of the public health.

"(5) That the Council continue in coöperation with the State Board of Health, to the extent that such coöperation is practicable, and that efforts to secure the enactment of a modern, up-to-date sanitary code be continued.

"(6) That the position of the Association in the matter of obstetric and pediatric care for families of enlisted men as set out in the resolutions on the subject recited in this report, be continued.

"(7) That the decision of the Council to hold the regular annual meeting this year, be approved."

In connection with mandate No. 1, it should be remembered that the report itself contains two highly important resolutions which had been adopted by the Executive Council and which had to do with such matters. The first of these resolutions recites the fact that the medical profession as an organization was constantly being solicited to enter agreements and contracts of a great variety, covering the practice of medicine in part or as a whole under all sorts of conditions, most of which were subsequently embarrassing, and some of which were impossible of accomplishment. Therefore it was resolved.

"First: That the State Medical Association of Texas, its component societies, committees, bureaus, representatives and officers be advised and directed as such, not to sign or agree to any plan, agreement, or contract sought for the purpose of providing hospital and medical care for any designated group or groups.

"Second: That any physician as an individual is free to make any agreement or contract with any group, agency, or organization for the purpose of rendering his medical care and services to any persons designated and agreed upon. All fees and all terms of any contracts or agreements made and entered into to be decided and fixed by the physician as an individual and any agency or any authority which may be a party to the contract.

"Three: The medical profession never has, does not now and never will seek to escape any duties or obligations. We yield to no group when loyalty and devotion are called upon to protect the interest and welfare of our people."

The report further called attention to the fact that the decision was not against the study by agencies of the Association of problems mutual to

it and either governmental or other groups, and that in no instance does the interdiction apply to the individual member. There are other rules and regulations under which the individual may be reckoned with, such as certain parts of the Principles of Medical Ethics, particularly those which bear upon the economics of medicine.

Of necessity the Executive Council has refrained from doing more than study the mutual problems posed by certain governmental agencies and other groups. At the time the above mentioned resolution was adopted by the Executive Council, the Council on Medical Economics was in the midst of sustained efforts to bring about an agreement between the Children's Bureau and the State Medical Association in the now well understood predicament of the E. M. I. C. program. It may be doubted as to whether any good would have come from the continuation of any such negotiations, and apparently nothing could possibly be done now, but there are other phases of governmental and public welfare activities in which doctors are concerned, notably, the effort to provide medical and surgical service on a prepayment basis, through whatsoever agencies, particularly nonprofit coöperative societies, or companies, which not only should be studied but in which some decision should be made, and even contract or agreement accomplished. This cannot be done at the present time, under the resolution referred to above.

The House of Delegates by approving the report of the Executive Council mentioned, has approved the policy mentioned. The Executive Council is of the opinion that this policy should be modified, or even abandoned, pending stabilization of the whole problem of the distribution of medical service.

A resolution bearing upon the E. M. I. C. program will also be found in the above mentioned report. It should be read and re-read, and definitely understood by the entire medical profession of Texas.

After setting up the circumstances, the resolution recites the fact that every licensed physician is free as an individual, exercising the rights of private enterprise, to render his professional services as and when he may so desire. The Executive Council observed in this connection that:

"It is clear that the purposes of the above quoted resolution are merely to prevent medical organizations from so prejudging terms and conditions of service to be rendered by individual physicians under governmental direction as either to coerce or inhibit the individual physician in dealing with the government in such matters, and to leave it to the individual physician as to what he shall do about it on his own. Nothing else is necessary. There are provisions of medical ethics for dealing with such cases as would be injurious to the public welfare in medical matters.

"What the medical profession should really seek to bring about in such programs as that set up by the Children's Bureau for obstetric and pediatric care for families of enlisted men, or any other such service, is recognition of the fact that the doctor and his patient should enjoy the usual contractual relationship, and that any subsidy from the government should be looked upon as aid to the needy, and therefore should be paid to the needy for the purchase of such service as may be needed, exercising only nominal control over the matter as to persons employed or the terms of employment. The principal concern of the government in the matter should be that adequate and competent service is purchased, and the money not frittered away in the employment of quacks and cultists. Looking at the matter in this light it is clear why the above quoted resolution was adopted by the Council."

Presumably no good would come of any resumption of negotiations with the Children's Bureau in such matters, but there are other situations of the sort which may develop, and it is a question as to just how far the State Medical Association, through whatsoever group, should go in setting up agreements. The Executive Council is still convinced that it should not be possible for any agency of the State Medical Association to bind its members to any contract involving the practice of medicine, or any part of it, but there would seem to be no reason why understanding and coöperative policies might not be set up in important emergencies such as presented now in the fight on socialized medicine.

The Executive Council has continued to oppose in every way possible the encroachments of socialized medicine, as directed. The efforts of the various agencies of the Association along these lines are probably well known, and at any rate they are too various and too complicated to receive detailed attention in this report. The reports of other groups of the Association will be sufficiently informative in this connection, we are sure.

However, the report of the Executive Council referred to above, which was the last report the Council has made, contains a very pertinent and expressive resolution pertaining to socialized medicine, and the original Wagner-Murray-Dingell bills, and it was directed that our delegation in the Congress be duly and fully advised as to our opposition to these and all other such measures, and only recently our Legislative Committee and our Committee on Public Relations, have seen to it that there can be no mistake about the matter. Socialized medicine is not an immediate problem so far as Texas legislation is concerned, but it easily could be and it may yet become such a problem, and our Legislative Committee is laying the predicate now to meet any such contingency.

The Executive Council has not been called upon nor has it had any opportunity to do much or anything about our war effort, as directed under mandate No. 3, but Procurement and Assignment Service has apparently been quite satisfactory. This service has changed somewhat in character and presumably has kept pace with the national group in its policy. It was discontinued as such, April 1, 1946. The Committee on Procurement and Assignment will report on that matter at this meeting.

As to support of the Committee on Medical Licensure in its plans for medical legislation, as called for in mandate No. 4, there has been very little for the Executive Council to do. The admonition that no controversial legislation be introduced in the State Legislature by the State Medical Association was duly observed, so far as the Executive Council is concerned, and so far as the State Medical Association is concerned, as for that. There had to be some counter-attacks, but our Legislative Committee apparently attended to all of that quite satisfactorily.

The Council has made every effort to coöperate with the State Board of Health in problems of concern to the State and the medical profession mutually, and, without going into great detail in the matter, it may be reported that some success was attained, particularly in support of our Legislative Committee pertaining to the public health, in all of which the State Board of Health was very naturally concerned. Certainly strenuous efforts were made to bring about the enactment of a sanitary code of modern construction and application (all in accordance with mandate No. 5, referred to above). The Legislative Committee will tell about that. The Executive Council conferred with the Legislative Committee in its October 8, 1944, meeting, with special reference to the development of a modern sanitary code, and the Council adopted the report of the Chairman of the Legislative Committee with reference to all of these matters.

A meeting between the Executive Council and the State Board of Health was decided upon and carried out.

The Executive Council, on March 14, 1945, adopted a resolution "that we oppose any law that limits the rights of hospitals to be the sole judge of the professional qualification of their staffs." The resolution was the culmination of a free and full discussion of H. B. 314, a measure providing for the admission of osteopathic physicians to practice in tax-free hospitals. The decision was to oppose this measure, and assist the State Hospital Association in its defeat. We may report here that the Legislative Committee and the Committee on Public Relations proceeded accordingly and with vigor, and quite successfully.

The previous report of this Council approved the idea of promoting a regular, full-dress meeting of the State Medical Association in 1945, if possible to hold such a meeting under the then existing war restrictions. At its meeting on October 8, 1944, the Council decided to proceed with plans accordingly, and it was voted that the meeting should be held in Galveston, May 7-10, 1945, both place of meeting and the dates thereof to be subject to revision by the Council in any emergency. It soon became evident that the restrictions as to the number of prospective attendants on meetings of the sort were such that no full-dress meeting could be held. For that reason, and after the Council on Scientific Work had arranged a very fine program in full, and many preliminary arrangements for the meeting had been perfected, it was decided not to try to hold such a meeting, and instead to ask federal authorities for the privilege of holding a meeting of the House of Delegates. It was considered that such a meeting was not only important, but necessary. The complications due to arise if no such meeting were held, were clearly evident and quite embarrassing. Application for the privilege of holding even this meeting was denied. There was nothing else the Executive Council could do about it, and the affairs of the Association, so far as the Council was concerned, remained *in statu quo ante.*

At its meeting on March 14, 1945, the Council adopted a resolution approving the appointment of Dr. O. F. Gober of Temple, to a vacancy on the Legislative Committee, and recommending to the House of Delegates that the appointment be approved and confirmed. This action was taken in view of the ruling of the State Secretary that under the By-Laws of the State Medical Association pertaining to such matters, the vacancy could not be filled by executive appointment. The Council is advised that following the adoption of the resolution concerned, Dr. Gober was officially accepted as a member of the Legislative Committee.

The Executive Council, acting within the purview of its duties as advisor to any group of the Association, in connection with any function, conferred with the Council on Medical Economics in the matter of prepayment plans for medical service. Chairman Dr. Griffin of the Council on Medical Economics reported that the Council had set up standards for the evaluation of such plans, whether in the form of policies issued by commercial insurance companies, or coöperative societies or associations. The House of Delegates had approved the recognition of such groups, provided their plans and policies were economically sound, and within the bounds of medical ethics. Following an extended and detailed discussion of the problems, the Executive Council approved these plans and policies.

Following the most recent developments in the problem of distribution of medical service, and under the leadership and direction of the Council on Medical Service and Public Relations of the American Medical Association, the Executive Council promoted a meeting between the Council on Medical Economics and the Committee on Public Relations for a joint discussion as to what should be done about it all immediately. There seemed to be need for prompt action. The Council on Medical Service and Public Relations of the A. M. A. very graciously assigned Mr. Jay Ketchum, an expert in this field, to attend the conference. Mr. Ketchum reported in ample time to make a thorough investigation of the field and particularly the Group Medical and Surgical Service, Incorporated, a statewide, nonprofit plan operating in this field in Texas, with apparent success. Following a full and free discussion of the matter, in which representatives of Group Medical Service participated, in order to get in line immediately with the national movement in the spread of nonprofit organizations of the sort, and thereby change the position of our Association from one of defense to one of attack, the following resolution was unanimously adopted by the Executive Council (March 24, 1946, at Fort Worth):

"That the Executive Council recommend to the House of Delegates that the State Medical Association of Texas approve any statewide plan that meets the standards of acceptance of the Council on Medical Economics of the State Medical Association and the standards of acceptance of the Council on Medical Service and Public Relations of the American Medical Association; and

"Further, that the State Medical Association place its approval or 'acceptance' on Group Medical and Surgical Service, Inc., or any other statewide nonprofit plan that makes provision in its by-laws for representation on its board of directors in numbers satisfactory to the State Medical Association, of physicians nominated by the State Medical Association of Texas; and

"Further, that Group Medical and Surgical Service, Inc., or any other similar statewide plan to be so approved shall provide in its by-laws for an adjudication committee of nine members from the State Medical Association representing all branches of medicine, the duties of which committee will be to determine the relative values of medical services and procedures as expressed by the plan's published schedule of benefits, and of those services and procedures not published."

The Executive Council realizes that it has no authority to bind the State Medical Association to any such procedure as that outlined above, but there are agencies in the Association which can act, and the Executive Council is recommending that they act, and in accordance with the above quoted resolution. This recommendation will apply particularly to the Council on Medical Economics and to the Committee on Public Relations, and, of course, to this House of Delegates, the action of which is final.

Rather directly in line with the above recited discussion and decision, the conference between the Executive Council, the Council on Medical Economics and the Committee on Public Relations, at which the above mentioned resolution was adopted, decided that the presently much discussed coöperative hospitals being organized under a law passed by the last session of the Legislature, some of which are being operated without regard to medical ethics or the good judgment of the medical profession locally, should be dealt with directly by the Committee on Public Relations of the State Medical Association, with the counsel of whatsoever agency of the Association it may desire, in the hope and expectation that such institutions will be useful in promoting the prepayment plans of distributing medical service throughout the State. The Conference was of the opinion that our Public Relations Committee can settle all matters of medical ethics and medical economics involved, in one or more across-the-table discussions. It is recommended that this action be approved by this House of Delegates.

In line with the discussion just recited, the mat-

ter of the hospital and medical service survey of the State, anticipating the passage and operation of the so-called Hill-Burton bill, the participation of the State Medical Association through the Advisory Commission recently appointed by the Governor of the State, was approved, and it was generally agreed that this Advisory Council should remain as at present, exclusively a group of doctors and hospital administrators. The suggested addition to the Advisory Commission of representatives of lay groups of a variety, should be set up later on, after the technical details and professional matters involved have been thoroughly thrashed out by the medical and allied professions. It is recommended that this House of Delegates approve such a policy.

The Conference mentioned likewise decided that the matter of participation by the State Medical Association in the much publicized Veterans Administration program had better be left in the hands of the medical profession locally, and will have to be so left until the resolution referred to at the beginning of this report, which inhibits the State Medical Association or any of its subordinate bodies from making contracts or agreements with anybody covering the actual practice of medicine, has been abrogated, or so modified as to permit such action. There certainly can be no objection to the doctor individually agreeing to serve the Veterans Administration in any capacity he chooses and has the opportunity to serve, under the well known provisions of Medical Ethics with reference to such matters. There has been no demand that any part of the Principles of Medical Ethics be abandoned in the suggested plan of medical service for the veteran, and it is not expected that any will be made. However, there are possibilities, and certainly opportunities for those in authority who do not greatly respect medical ethics, or more to the point, do not understand them, which fact must be borne in mind. It is recommended that the policy thus expressed be approved by this House of Delegates as the policy of the State Medical Association with regard to such matters.

The pending survey by the American Academy of Pediatrics, looking to a determination of the extent and character of medical service available in that field, and which should be made available, was considered in detail, and the decision eventually reached that there should be no intervention in the matter on the part of the State Medical Association, at least for the present.

It Is Recommended:

(1) That as heretofore, the Council continue to coöperate with organizations and groups active in the interest of public health and welfare, including governmental agencies, provided such coöperation does not involve the commitment of any member or group of members of the Association to any definite plan of practice, or fee schedule. The distinction between "coöperation" and "obedience" should continue in mind, and coöperation should be accorded only those groups which actually "coöperate" and do not attempt to exact "obedience."

(2) That opposition to movements leading to the socialization of medicine, whether legislative or otherwise, be continued vigorously, with all the force and influence the Association can command, and through whatever agency may with propriety be called upon to act.

(3) That the Executive Council be directed to coöperate closely in the development of prepayment plans of medical service, in accordance with the policies of the American Medical Association with regard to such matters, and in accordance with the resolution on the matter herein quoted.

(4) That the Executive Council be directed to continue in support of the Legislative Committee in promoting and opposing legislation in accordance with the decisions of this House of Delegates, and decisions in joint conference between the Executive Council and the Legislative Committee.

(5) That the Executive Council continue to coöperate with the State Board of Health in promoting health activities and health legislation, so long as the Principles of Medical Ethics of the Association are respected by the Board of Health and the federal agencies with which the Board must coöperate in its functioning.

(6) That the position of the Association in the matter of obstetric and pediatric care of families of certain members of our Armed Forces, as per resolutions heretofore adopted by this House of Delegates, be continued, and extended to cover the development of these plans into further practice as per the so-called Pepper bill, pending in Congress.

(7) That the right of the President to fill a vacancy on the Legislative Committee created by the failure of the House of Delegates constitutionally to elect a member, as recommended by the Executive Council, be approved.

Respectfully submitted,
H. F. Connally, Chairman,
Holman Taylor, Secretary.

President Connally: The report of the Executive Council will be referred to the Reference Committee on Reports of Officers and Committees, except that part referring to a Prepayment Plan for Medical Service, which will be referred to the Reference Committee on Medical Service and Public Relations.

The Council on Scientific Work.

Dr. A. C. Scott, of Temple, Chairman, presented the report of the Council on Scientific Work, as follows:

REPORT OF COUNCIL ON SCIENTIFIC WORK

The Council on Scientific Work met on January 14, 1945, in Fort Worth, and considered the completion of the program for the annual session for that year. By vote it was agreed to accept the report of the Committee on Scientific Exhibits and to recommend to the Executive Council that no attempt be made to put on a scientific exhibit at the annual session.

The Council discussed thoroughly the question of holding the annual meeting, in view of the government's request that no meetings of any kind be held with over fifty present. By a majority vote of the members present, a motion was passed recommending to the Executive Council that in accordance with the request of the national government the meeting not be held; and that no request be made of the Office of Defense Transportation for permission to hold such a meeting.

In the discussion it was brought out by the Secretary that the Executive Council might decide to make a request for the holding of such meeting, and in view of this fact the Council proceeded with its work to outline a complete program, going over the reports of each section chairman and secretary, it being agreed that a program would be completed, and if the meeting were not allowed, the papers would be available for publication in the Journal.

In view of subsequent happenings, namely, the request of the Executive Council to the national government to permit holding the meeting, and the government's denial of the request, no further work was done by the Council.

Following the failure to hold an annual session in 1945, the Council on Scientific Work did not meet again until February 24, 1946. The delay in meeting was caused by the resignation of a number of former Section Officers, and the inability of the new officers to get their programs arranged by January 15.

The meeting in Waco on February 24 was at-

tended by practically all of the Section Officers, the President and Secretary and the Assistant Secretary of the Association, and two members of the Council. Revision of the "Memorandum for Council on Scientific Work" was brought up for discussion, and certain revisions pertaining to the mechanics of the meetings were approved. A number of previous customs and rulings of the Council which had not been printed, were ordered incorporated in the revised compilation. The Council then considered the programs as presented by the various sections and approved these programs.

In spite of the short time the Section Officers had in which to arrange their programs, practically all programs were fully completed and were of excellent quality; and it was felt by the Council and the Association Officers, that the next annual session, in May of this year, will be presented with one of the best, well-rounded programs we have had for many years.

The Council wishes to take this opportunity to thank the various Section Officers for their splendid efforts under trying circumstances.

Respectfully submitted,

A. C. Scott, Chairman.

President Connally: The report of the Council on Scientific Work will be referred to the Reference Committee on Scientific Work.

The report of the Council on Medical Economics.

Dr. H. E. Griffin, of Graham, Chairman, presented the report of the Council on Medical Economics, as follows:

REPORT OF COUNCIL ON MEDICAL ECONOMICS

This report necessarily covers a two-year period of time because of the exigencies of war. The Council has been handicapped, as has been the case with practically all other groups of the Association, due to travel restrictions set up as war measures. The State Medical Association has observed these restrictions in their entirety.

Governmental control during war is tolerated by all, freely and voluntarily, but when war is over citizens of all walks of life should be relieved of as much governmental control as is compatible with public security. The business of the medical profession is no exception to this rule.

Your Council on Medical Economics is impressed with the fact that many metropolitan dailies and local newspapers are showing keen and enthusiastic interest in the effort of the medical profession to inform and thoroughly arouse the general public regarding the malevolent features of the Wagner-Murray-Dingell Bill, and similar national legislation. We regret that equal publicity has not been given all the bills which would interfere with progressive, scientific medical endeavor on a free enterprise basis, among which measures we might mention Maternal and Child Welfare Act of 1945 (S. 1318), better known as the "Pepper Bill." This bill is a vicious extension of the orginal EMIC program, instituted by bureaucrats and tolerated by our profession as a war measure. This bill envisions an annual expenditure of public funds of more than one billion dollars.

The major problem of your Council during the past two years has been that of prepayment plans for furnishing medical service. It is reported that there are in operation in the United States sixty-one plans of prepayment medical and surgical coverage, practically all of which are supposedly nonprofit. All are presumed to offer adequate coverage for subscribers, and are reported to be operating well.

Several plans have been set up by corporations, many of which are entirely financed by the corporate owners, with no expense to the employee, but with full coverage. In some instances, the expense is shared equally by the employer and employee. Outstanding among these plans are those underwritten by major insurance companies, whether the participation is in equity between employer and employee or borne solely by the employer. Employers throughout the country endorse such plans almost without exception, in that there is more satisfaction among employees, less absenteeism, and above all, better health among employees.

Our Council is fully aware of the entrance of insurance companies, mutual associations, and medical and surgical services, into the field of the indemnity and nonprofit care of the sick and injured. Some have sought the approval of our Council. It is our purpose eventually to establish a program under which carriers of all kinds will be encouraged to seek the stamp of approval of our Association, and/or the county medical societies of the state. Many of the plans and policies of these organizations are under careful consideration at the present time.

We are impressed with the possibility that the traditional patient-doctor relationship may be materially interfered with in some of these plans. The patient-doctor relationship is a sacred trust in America and should remain as such. In setting up such service, necessarily there appear the intermediary functions. These are important as far as the patient and the doctor are concerned. The intermediary should be manned and controlled by the medical profession. Good coöperative results are in evidence where such control exists. There are reports of success in states and localities where lay-intermediary management exists. In some states, medical associations have boldly launched into the insurance field, owning and controlling all such service. They express satisfaction as to results.

Your Council is concerned that the average coverage of many insurance companies, associations, and nonprofit services is far below the average surgical fees in any localities, ranging from about 50 to 60 per cent. The matter of medical-surgical coverage is an important one, requiring much consideration. The general tendency is, in the end, to establish a minimum fee for physicians and surgeons, which matter should attract the attention of the entire medical profession. Should we concur and take chances in the fee problem caring for itself by insurance volume, as shown by the reports of some of the nonprofit plans?

We are all familiar with the many medical schemes which have been promulgated by the government the past decade. The FSA scheme, while apparently of some economic benefit to a few doctors in some sections, was generally of little value, and nothing is heard of it now. The experimental health trial balloons in a few counties in several states have not been at all successful. The experiment has not been a pleasing or profitable one for the people or for the doctors. Mention has been made in a previous report by our Council of the many discrepancies in such schemes promoted by the government.

Interest in such matters is being stimulated by the coöperative hospital law passed by the forty-ninth Legislature of Texas, which law enables communities of twenty-five hundred or less population to organize community-farmer stock coöperatives to build hospitals and furnish medical service. Some coöperatives are not only attempting to build, finance, and operate such hospitals, where physicians may render service to the people, but are endeavoring with pooled funds to hire physicians on a salary basis to render such service under circumstances where there would be no free choice of physicians. Physicians engaging in such projects should give serious thought to the

possibility of malpractice suits, because all physicians so engaged are responsible.

However, such coöperatives organized and operated under strict and proper ethical standards as set forth by the State Medical Association, could offer satisfactory medical and surgical services to rural communities.

That nothing has been said by advocates of socialized medicine bills, plans, and schemes about care of the actually indigent, is quite noticeable. This Council is impressed with the possibility of coöperation in an effort to establish a proper regime through which an equitable distribution of funds for the care of the actually indigent might be successfully carried out.

After mature consideration, your Council has adopted a minimum set of principles that should be met by any plan operating in our state that seeks acceptance at the hands of the State Medical Association. These principles were set up early in 1945, and through the activity of our Public Relations Committee immediately attracted the attention of the Public Relations and Rural Medical Service Committees of the A. M. A. both of which commented upon them favorably. These principles, or standards, are as follows:

1. Insurance companies should be solvent.

2. Nonprofit insurance companies shall be as nearly nonprofit as is consistent with sound business principles and practice.

3. Insurance companies should avoid advising subscribers to consult any certain doctor or doctors. In general, policies should conform to the usages of Medical Ethics, and specifically there should be free choice of doctors, and no interference with the traditional doctor and patient relationship.

4. Insurance companies should cause to be stated on the face of their policies that the amount allowed in the policy for medical care does not necessarily cover the charges of the doctor for his services.

5. Insurance companies should not provide payments to any hospital or hospitals for the services rendered the injured by any doctor.

6. It should be recognized that insurance companies are at the present time forced to feel their way in hospital and sickness insurance and that changes in plans and procedures may be necessary from time to time for several years.

It will be recognized at once that the problem of determining just which insurance policies comply with these principles, and which do not comply and in what particulars, is an intricate one. It will be noted that the principles referred to above create a situation which is rather elastic. They contemplate a give and take policy of operation and development.

This service cannot be rendered in a manner wholly satisfactory to the State Medical Association as a side responsibility of the State Secretary and the Central Office. Expert advice will be required, and this advice should be rendered by an insurance specialist. Also, additional clerical service will be needed. There must be administrative control. It is, therefore, recommended that the Board of Trustees of the Association be requested to make an appropriation to cover. It is impossible at this time to estimate what the service will cost. We feel that we should develop the service fast enough to protect the medical profession of Texas in the same manner that all coöperative groups are protecting their interests. We say again, it should be a matter of serious concern to the medical profession that American business is working day and night to protect *Free Enterprise.*

At a recent meeting the Executive Council of the State Medical Association recommended that "Group Medical and Surgical Service, Incorporated, or any similar statewide plan to be so approved shall provide in its by-laws for an adjudication committee of nine members from the State Medical Association representing all branches of medicine, the duties of which committee will be to determine the relative values of medical services and procedures as expressed by the plan's published schedule of benefits, and of those services and procedures not published." We are impressed with this idea, and stand ready to coöperate with this committee and any other agencies involved, in bringing about a protective program for the care and betterment of public health.

At its December meeting, the House of Delegates of the A. M. A. directed the Board of Trustees and its Council on Medical Service and Public Relations, to proceed promptly with the development of a national organization of locally administered prepayment medical plans sponsored by the medical societies. The Board of Trustees and the designated council immediately laid down a national health program accordingly, and went all out, among other provisions, for a militant and wide development of locally administered prepayment medical insurance plans. These and similar plans already in operation are to be integrated under a voluntary national organization to be known as Associated Medical Care Plans.

The individual plans may offer cash indemnity or service units to be joined with the National Corporation. Each plan must develop certain standards of operation that are acceptable to the Council on Medical Service of the A. M. A., which will enable the local and state plans to use the seal of acceptance of the American Medical Association. This means that the operational standards of the medically sponsored, nonprofit, prepayment plans from here on will largely be prescribed by the American Medical Association on a nationwide scale.

The national plan envisions a wide exchange of benefits for the individual and for groups, as between plans in separate communities or states. The rules for acceptance as formulated by the A. M. A. Council on Medical Service, have not as yet been officially brought to the attention of our Council. However, all local prepayment plans must be cleared by the State Medical Association before receiving consideration by the American Medical Association.

The Board of Trustees of the American Medical Association has established a division of prepayment medical care plans, with a director, and a staff, who will administer the activities related to the promotion and development of medical care plans in all states. However, it is not yet made clear as to the reciprocal relations of this establishment and the projected "Associated Medical Care Plans."

It will be remembered that this House of Delegates, at the 1944 annual session, gave full endorsement in principle to prepayment plans, while adopting a policy of watchful study of other State Association sponsored plans, without any definite plan of action on our part. It was assumed that the State Medical Association could best serve the interests of the people of Texas by encouraging the growth of county society plans, or commercial plans, as the needs and desires of communities, or groups of communities, developed through local initiative and leadership.

The State Medical Association, through its Council on Medical Economics, was to explore all such plans that were presented, with due regard to the Principles of Medical Ethics, and require certain standards of conduct as a prerequisite for approval. It was believed that insurance companies, through adoption of these rules, would make certification of acceptance an assurance of protection to policyholders, as well as of value to prepayment plans in broadening their business fields.

Such procedure as above outlined should prove an all-around assistance to the concept of insurance protection against the emergencies of ill health.

Respectfully submitted,

H. E. Griffin, Chairman,
H. R. Dudgeon,
W. R. McWilliams,
W. F. Starley,
W. A. Lee.

President Connally: The report of the Council on Medical Economics will be referred to the Reference Committee on Medical Service and Public Relations.

At 12:45 p. m., President Connally declared the meeting recessed until 2:00 p. m.

Afternoon Session

The afternoon session was called to order at 2:00 p. m., by President Connally.

Second Report of Reference Committee on Credentials

Dr. J. M. Campbell, of Goldthwaite, member of the Reference Committee on Credentials, reported that 112 delegates had been seated.

President Connally: The report of the Legislative Committee, by Dr. John H. Burleson, Chairman.

Dr. J. H. Burleson, of San Antonio, Chairman of the Legislative Committee, presented the report of the Legislative Committee, as follows:

REPORT OF LEGISLATIVE COMMITTEE

Your Legislative Committee feels that it has followed a negative policy long enough; to continue means defeat. Had the cult bills come to a vote in the recent session of the Legislature they would probably have passed. This negative policy is the cause of the charge that we have reached an all time low in our influence in the Legislature and with the public. Neither the Legislature nor the public has changed. The Chairman of the Legislative Committee has long been of the opinion that our Association should stop fighting cults, as this places us on the defensive and leaves the impression of being selfish and not in the interest of public health and the man on the street who cannot pay his doctor. We have been warned by our friends in the Legislature that we must submit a tenable, positive solution on medical licensure or the Legislature will be compelled to regulate the cults without the expert advice of the medical profession.

We wish to open this report with a short outline of the duties of the Committee. The Legislative Committee was created by the House of Delegates; it is a standing committee, a part of our organic law. It was the impression of the Committee that its functions were understood by the membership. Situations have arisen during the past Legislative year which demonstrate that some of our members have a very hazy understanding of its functions, and have been guilty of hysterical outbursts not in keeping with good individual deportment, which certainly does not add dignity to our great profession.

We call your attention to the fact that the Legislative Committee is not a policy making body. It does not initiate legislation. It works under mandates of the House of Delegates.

If proposed legislation is presented to the Committee between meetings of the House of Delegates, the Executive Council is called to outline policies of the Association which your Legislative Committee must follow. Last year the House of Delegates gave us the following mandates—they are directions, and not suggestions:

"1. That the Council be directed to continue the policy of the Association at present in force as relates to coöperation with organizations and groups interested in public health and welfare, including governmental agencies, and refraining from coöperation with any such which fail to recognize the proper place of the medical profession in connection with such matters, and under a realistic interpretation of the term 'coöperation,' in contradistinction to 'obedience.'

"2. That the Council continue to oppose movements leading to the socialization of medicine through whatsoever procedures, always in consideration of the proper demands of war service.

"3. That the Council continue its unreserved coöperation in the war effort, making due distinction between real war effort and pseudo war effort.

"4. That the Council continue in support of the report on Medical Licensure in its plans for medical legislation, with the understanding that no controversial legislation of the sort be undertaken at the present time, except under emergency situations which may arise and which may jeopardize the interests of the public health.

"5. That the Council continue in coöperation with the State Board of Health, to the extent that such coöperation is practicable, and that efforts to secure the enactment of a modern, up to date sanitary code be continued.

"6. That the position of the Association in the matter of obstetric and pediatric care for families of enlisted men, as set out in the resolutions on the subject recited in this report, be continued.

"7. That the decision of the Council to hold the regular annual meeting this year be approved."

These instructions, as above stated, are mandates to the Executive Council and the Legislative Committee.

On October 8, 1944, the Executive Council met in Fort Worth, Dr. Frank Connally presiding. The State Health Officer and members of his staff were present. The following bills, endorsed by the State Board of Health, were submitted to the Council by the State Health Officer: (1) Sanitary Code Bill, (2) Communicable Disease Bill, (3) Premarital Bill, (4) Prenatal Bill, (5) Standard Health Unit Bill. After much study and discussion and with several amendments, these bills were approved by the Executive Council.

On January 23, the Legislative Committee met in Austin, at the headquarters of the State Health Department, Dr. J. H. Burleson presiding and Dr. Frank Connally attending the meeting, to consider a tuberculosis program sponsored by the State Health Department and endorsed by the State Board of Health and the Texas Tuberculosis Association. After much study and discussion, two bills were endorsed by your Legislative Committee. All of these bills will be discussed elsewhere in this report, in their order. This report contains about sixty bills bearing on public health and the practice of medicine that were introduced in the recent session of the Legislature. It may appear that a lot of these bills were not worthy of notice and the space allotted to them. We will explain, however, that Mr. Jeff L. Reese, who represents the Association at Austin, is directed to report the introduction of all such bills and keep up with the status of each of them and keep the Legislative Committee advised. Mr. Reese has long represented our Association, and is thoroughly conversant with legislative procedures. Your Legislative Committee commends Mr. Reese for his valuable services. The most innocent looking bill, as shown by its caption, can easily be the predicate for vicious legislation. For instance, H. B. 827 looked innocent when introduced, but the real purpose of the bill was to destroy our Board of Health law by replacing four doctor members with laymen; therefore, it is important that all such bills be carefully watched. For the information of all concerned a list of these bills is attached as exhibit "A."

The Committee feels that the following bills deserve special mention and explanation:

The Sanitary Code was known in the Legislature as H. B. 10 and S. B. 81. A review of the mandates from the House of Delegates for the past twenty-five years reveals that the Legislative Committee and our Executive Council, have been instructed to revamp the old, outmoded Sanitary Code. Over the years many bills have been introduced to that end. The bill which finally passed was introduced by Senator J. Franklin Spears, of San Antonio. The Chairman of your Legislative Committee and Dr. L. H. Reeves, a member of the Committee, appeared before the Health Committee in the Senate in behalf of these bills, and with the aid of the State Health Officer, Dr. George W. Cox, and members of his staff, we were able to convince the Committee that this was meritorious legislation. The Committee voted the bill out favorably. Senator Spears succeeded in getting the bill up on the floor of the Senate, and it passed. It was sent to the House of Representatives and referred to the Committee on Public Health in the House. Representative John C. Hoyo, of San Antonio, who was author of H. B. 10 (same as S. B. 81) directed the hearing before the Health Committee. The Chairman of your Legislative Committee, State Health Officer, Dr. George W. Cox, and members of his staff, presented the bill to the Committee. The Committee reported the bill favorably and Representatives Hoyo and R. L. Reader, both of San Antonio, succeeded in getting it up on the floor of the House, and it finally passed. It was sent to the Governor, who filed it with the Secretary of State without his signature. It became a law ninety days after adjournment of the Legislature, about September 5.

Communicable Disease Bill, S. B. 29, was introduced in the Senate by Senator L. J. Sulak. The same bill was introduced in the House by Representative George Parkhouse (H. B. 73). These bills were reported favorably by the House and Senate Health Committees, but owing to interference, not necessary to discuss here, and the congested condition of the calendar, the sponsors were never able to get them up for consideration. The same happened to H. B. 160, by McMurray and Parkhouse (Prenatal Bill), and H. B. 1611 by Parkhouse and McMurray (Premarital Bill).

Tuberculosis Appropriation Bills, H. B. 196 and H. B. 197, were introduced in the House by Bell and Reader, of San Antonio, and Price, of Tyler, and referred to the Committee on Appropriations. The Chairman of the Legislative Committee and Mayor Gus Mauermann, of San Antonio; Miss Pansy Nichols, Executive Secretary of the Texas Tuberculosis Association; State Health Officer, Dr. George W. Cox, and members of his staff, appeared before the Appropriations Committee in behalf of these bills. We were successful in getting the Committee to make H. B. 196 (an appropriation for $100,000) an item in the Departmental Bill. This item was adopted by the House of Representatives, but the appropriation was lost in Free Conference Committee. H. B. 197 died in the committee. We seemed to be up against too much power in our undertaking to get these bills approved. The Governor had adopted a policy of economy. The Chairman of the all powerful Appropriations Committee was not favorable to any appropriations that were not included in the budget by the State Board of Control. The State Board of Control did not include these items in its recommendations.

The Standard Health Unit Bill, H. B. 222, by Pruit, of Travis, (same as S. B. 151 by Senator Kyle Vick). A substitute for this bill was reported favorably by the Public Health Committee of the House. We were informed by the State Health Officer that the substitute was unsatisfactory to that department, and your committee abandoned support of the bill. It did not pass.

A review of the accomplishments of your State Association officers during the session of the 49th Legislature makes Dr. Frank Connally's administration an all time high instead, as many would have you suppose, an all time low in outstanding legislative accomplishments. I quote from Public Relations Committee News Letter 11:

"Some sixty bills bearing on public health or the practice of medicine were introduced before the last session of the State Legislature. The Legislative Committee of the State Medical Association was instrumental in defeating every single one of these bills which was dangerous to public health or detrimental to Texas medicine. Not a one of them got by.

"All of the bills mentioned were strongly advocated by the cults and their attorneys. It required hard work on the part of the Legislative Committee to defeat these objectionable measures.

"Physicians of Texas who took the time and trouble to write their legislators in opposition to the dangerous bills are thanked and commended by their Legislative Committee to whom they gave this valuable aid."

The following bills were introduced in the House and Senate which would amend or affect the *Medical Practice Act and the practice of medicine*: H. B. 29, H. B. 34, and S. B. 57 (Chiropractor Bills); H. B. 82, H. B. 97 (Naturopath Bills); H. B. 720 (Chiropractic Bill); and H. J. R. 59 (Proposed Amendment to the Constitution). These bills are very ably discussed and analyzed in the February, 1945, issue of the TEXAS STATE JOURNAL OF MEDICINE. Suffice it to say here, all of these bills failed to pass. H. J. R. 59 was an effort to amend the Constitution to cure the objections raised by the Court of Criminal Appeals. The President of the State Medical Association, the Legislative Committee, and numerous other officials of the Association made many appearances before the House and Senate Committees in opposition to these bills. Our support and the coöperation of the official family, the central office, the Woman's Auxiliary, and the regular members of the State Board of Medical Examiners, could not have been better.

A situation arose after the convening of the Legislature, when H. B. 314, by Simpson, of Tarrant County, and Westbrook, of Jasper County, known as the Osteopathic Hospital Bill, was introduced in the House of Representatives, February 12, 1945. It will be recalled that the last meeting of the Executive Council was held on October 8, 1944. The last meeting of the Legislative Committee was on January 23, 1945. The Executive Council did not have an opportunity to study this bill nor did the Legislative Committee. When it was introduced, in the absence of instructions, your Committee took the position that it would be the best strategy to let the Hospital Association lead the fight against this bill. Each member of the Legislative Committee was opposed to the bill, but a poll of the Committee showed that it was the opinion of the Committee that if the Hospital Association would lead the fight, line up the various churches and organizations affected by the bill, and get individual doctors to write their Representatives and Senators, the bill could be defeated without the State Medical Association, as a corporation, officially condemning the bill. A similar situation arose in 1935, when Dr. S. E. Thompson was President, and the Chairman of your Legislative Committee was President-Elect. The osteopaths caused to be introduced at that time two bills similar to H. B. 314. These bills were known as S. B. 346, by Small, of Amarillo, and H. B. 464, by Colquitt, of Dallas. The same strategy was followed in opposition to these bills, which proved successful. I quote from the report of the Executive Council,

as published in the June, 1935, number of the TEXAS STATE JOURNAL OF MEDICINE:

"Our greatest concern has been over a matter which should not be our concern at all. The osteopaths of the state have caused to be introduced a measure which would compel tax exempt hospitals to accept on their respective visiting staffs, any physician who has been licensed to practice medicine in the state, with the evident intention of procuring admission to the hospitals for themselves. We have resisted this legislation, not because of the sectarian interest involved, but, rather, because of the large number of unethical, unscientific and unworthy physicians who are legally practicing medicine in the state. It would be exceedingly hazardous to scientific and ethical standards, to take away from hospital managements their right to control the personnel of their respective visiting staffs. And, perhaps more practically to the point, the effect would be hazardous from the standpoint of medical malpractice. Hospitals would be forced to pay taxes or at once accept the status of second rate institutions. Many of them would be destroyed financially by the added cost of taxes, and reputable physicians would very generally withdraw their support of hospitals which would admit to practice by their aides, the class of physicians sure to take advantage of such a situation. In contending against this legislation, we have joined with the Texas Hospital Association, which organization is, very naturally primarily concerned."

Again in 1937, the same bill was introduced by Hardin, of Limestone County, and was known as the "Osteopath Hospital Measure." We quote from the report of the Executive Council, printed in the June, 1937, TEXAS STATE JOURNAL OF MEDICINE:

"The Osteopathic Hospital Measure came up again, introduced this time only in the House (by Representative Hardin, of Limestone County). The measure was a slight improvement over that of last year, but it at the same time carried the very objectionable provision that any physician licensed by the State of Texas must be admitted to practice in any tax-free hospital, provided he is professionally and ethically clean. Such a provision will be at once recognized as thoroughly impracticable, as pertains to a law. No hospital board would care to exclude physicians from practice under the circumstances, because of the danger of damage suit. It is difficult if not impossible to go into court and prove even the recognized factors which go to make up quackery and incompetence in the practice of medicine. The measure could not be made to apply merely to the osteopaths. And while it applies only to tax-free hospitals, it has not been felt that these hospitals should be made to exchange their birthright for a mess of tax-exemption pottage. Whether hospitals should be relieved of the necessity of paying taxes would not enter the case. For this reason, our Legislative Committee joined the Texas State Hospital Association in opposing this measure. The measure was killed in the Health Committee of the House by a vote of twelve to one. It never had a chance."

The above quotations from the report of the Executive Council in both 1935 and 1937 are recited to show that no meeting of the Executive Council was called to instruct the Legislative Committee as to strategy or legislative tactics. The Legislative Committee was on the ground, in contact with members of the Legislature, and it was presumed knew how to handle the situation.

Your Committee may have adopted the wrong strategy regarding H. B. 314, but the important thing is, the bill did not pass. How it was killed and who killed it does not seem to matter now. Each member of the Legislative Committee, we are sure, is in agreement with all ethical doctors that this was dangerous legislation and should have been defeated.

S. B. 181, by Moffett, was known as the *Coöperative Hospital Bill.* This bill was introduced in the Legislature and, like H. B. 314, neither the Executive Council nor the Legislative Committee, had an opportunity to study it. As soon as the bill was introduced, copies were sent to the Council on Medical Economics of the State Medical Association for advice as to its merits or demerits. The Council did not advise your Legislative Committee. If the Hospital Association had any objection to this bill, the information was not conveyed to your committee. We did not support or oppose the bill. The bill, in brief, provides:

"An Act amending Article 1302, Title 32, Revised Civil Statutes of Texas, by adding a new section thereto to be known as '2A' authorizing the creation and operation of charitable corporations for the purpose or purposes of owning and operating nonprofit coöperative hospitals, and for the purpose of providing medical, dental, health, surgical, nursing, hospitalization, and related services and benefits, for the members and families of the members of such corporations; providing that such corporations shall not be deemed to be insurance companies and shall not be subject to the insurance laws of Texas; providing that such corporations shall not be authorized to be created and operated in towns or cities of more than twenty-five hundred (2,500) population, according to the last preceding Federal Census; repealing all laws or parts of laws in conflict with the provisions of this Act; if any clause or phrase of this Act is, for any reason, held to be unconstitutional or invalid, such decision shall not affect the validity of any remaining portions of the Act."

This bill was passed by both House and Senate, was signed by the Governor, and is now a law. There are other bills which probably deserve special comment, but space forbids.

Your Committee wishes to extend thanks to the Woman's Auxiliary of the State Medical Association for its splendid coöperation during the recent session of the Legislature. Without this help the cult legislation might have been passed. Mrs. Sam E. Thompson, President of the Woman's Auxiliary, and Mrs. S. H. Watson, Chairman of the Auxiliary Legislative Committee, addressed over 2,500 letters to the Auxiliary members and many of the doctors' wives who are not members of the Auxiliary, urging them to write to their Senators and Representatives in opposition to cult legislation, and in favor of our public health program. It is estimated that members of the Auxiliary wrote 10,000 letters to their Senators and Representatives, not to mention telephone calls and telegrams. The response was splendid, and the effect on the Senators and Representatives was very good. We call your special attention to the report of the President, Mrs. Sam E. Thompson, published in the June, 1945, JOURNAL.

Your Committee wishes to thank the Public Relations Committee of the State Medical Association for the valuable service rendered in supporting our public health program and in opposition to cultist legislation. The Public Relations Committee publicized the public health program. All of the bills endorsed by the Executive Council and the Legislative Committee, were sent to county medical societies prior to the convening of the Legislature. The Public Relations Committee used its News Letters in urging the membership of the State Medical Association to write to their Senators and Representatives in the interest of our public health program and in opposition to cult legislation.

Your Committee wishes to thank the Texas Tuberculosis Association for its valuable support of the tuberculosis program. In fact, this Association really carried the ball in an effort to secure liberal appropriation for a real tuberculosis program in Texas.

Your Committee wishes to thank the State Board of Health, the State Health Officer, and his staff for their valuable coöperation and advice throughout the session of the Legislature.

The committee also wishes to thank the central office for its fine coöperation. The central office and the Public Relations Committee sent out thousands of letters during the session of the Legislature, urging the membership to write their Senators and Representatives in favor of our public health program and in opposition to cult and other dangerous legislation. The response of the membership was splendid, considering how busy our doctors were through war times.

COMMENTS

1. Your Committee believes, and it estimates that an overwhelming majority of the membership of the State Medical Association believes, that our position before the recent Legislature was not tenable. In this connection, we call your attention to the report of the Licensure Committee, printed in the June, 1944, issue of the TEXAS STATE JOURNAL OF MEDICINE, which was adopted by the House of Delegates with the proviso that controversial legislation, meaning a Basic Science Law, not be introduced in the Legislature for the duration of the war, except under emergency situations. We think that we will have to proceed on the assumption that there will be no war when the regular session of the Legislature convenes in January, 1947. The Licensure Committee made a thorough study of medical licensure problems in Texas, and we believe the solution of this problem is to follow this Committee's recommendations, and carry out the mandates of the House of Delegates. The Committee is to be commended for its fine work. The Committee has made no further recommendations, and your Legislative Committee presumes it is the desire of the Association to stand pat on the bill prepared by our general attorney, which is attached to this report as Exhibit "B".

ACCOMPLISHMENTS OF THE LEGISLATIVE COMMITTEE LAST YEAR

1. The House of Delegates adopted the following resolution (see June, 1944, JOURNAL, page 106):

"That this House of Delegates approve in principle the prepayment plans for medical care as conducted by corporations, and look with favor on the formation of a medical plan to work in conjunction with group hospitalization on a nonprofit plan in the interests of the lower-income group." This amendment was offered by Dr. John H. Burleson and was acceptable to the makers of the motion. The motion as amended was adopted, and that part of the report was adopted.

This mandate from the House of Delegates to your Legislative Committee was carried out. Some may contend that this was not a direct mandate, but your Legislative Committee is of the opinion that if not a mandate it is ample authority for your Committee to proceed with the organization of this important work. Medical and surgical benefits to be sold in conjunction with Blue Cross Hospitalization are now available. The operation of its distribution is attached to this report as Exhibit "C".

2. *Sanitary Code.*—This has been an objective and mandate of the Association for over twenty years. It is now a law. We are informed by the State Health Department that the new law is a good start and easily enforced. It is not as comprehensive as desired, but future Legislatures can and will amend it. The Chairman of your Legislative Committee, and other members of the Committee, made many trips to Austin and appeared before the Public Health Committees of the House and Senate in the interest of this important legislation. The State Board of Health and the State Health Department gave us fine coöperation. Your Committee feels that this is a major accomplishment and will be of untold benefit to the public health.

3. Seven *Cult Bills* were defeated. All of these bills were designed to side step the courts and the Attorney General's opinion, in which they were held unconstitutional, and to amend the Medical Practice Act. These bills were no different from cult bills that have been introduced before the Legislature for the past twenty years. All concerned are familiar with the fact that it is an effort on the part of the cults to practice medicine without the education and preparation required by the Medical Practice Act. These bills were all killed by the same strategy we adopted to combat H. B. 314.

4. H. B. 827 was a measure which we think would have destroyed the State Board of Health. If enacted into law, it would have replaced four doctors on the State Board of Health with laymen. Your Committee spent considerable time and effort in opposition to this bill, and it was defeated. There are many other bills listed in Exhibit "A", which is attached to this report, that were defeated by the efforts of your committee, and deserve special mention but space forbids.

RECOMMENDATIONS

1. Your Legislative Committee recommends a definite program to help the medical officers of the Armed Services when they return to civilian practice.

2. Your Committee recommends that the doctors continue a positive, aggressive stand in opposition to the encroachment of socialized medicine.

3. Your Committee recommends that the mandate of the House of Delegates be carried out, and that the basic science bill prepared by our general attorney be introduced in the regular session of the Legislature in January, 1947, and that the Public Relations Committee of the State Medical Association be requested to publicize the provisions and merits of the bill through county medical societies, and any other medium it may select.

4. Your Committee recommends that coöperation with the State Board of Health be continued, in an effort to secure the enactment of modern, up-to-date public health laws.

5. Your Committee recommends that coöperation with the State Board of Medical Examiners be continued, and that the existing annual registration law be modified or repealed.

6. Your Committee recommends that coöperation with the Hospital Association be continued, and that all proposed bills which would interfere with hospital staffs be resisted jointly, and under the direction of the Hospital Association.

7. Your Committee recommends that the House of Delegates abandon the practice of creating special committees. Your Legislative Committee believes the Association has sufficient standing committees adequately to cover all the activities of the Association, and that special committees only serve to overlap, duplicate, and complicate the duties of the regular, duly constituted councils and committees, causing unwarranted criticism, misunderstanding and dissension.

Respectfully submitted,
JOHN H. BURLESON, Chairman,
H. F. CONNALLY,
HOLMAN TAYLOR, Secretary,
J. ALLEN KYLE,
JOE GILBERT,
N. D. BUIE,
L. H. REEVES.

Dr. J. H. Burleson: Before discussing this report,

I wish to read a letter some of you have seen, which I think will or should be of interest to this House of Delegates. During the last session of our Legislature, while your Legislative Committee and the officers of your Society were fighting the cults with their backs to the wall, letters from the Tarrant County Medical Society appeared. Copies were being circulated freely among our Legislators and proudly displayed by our enemies. These letters were offered as evidence that our members were divided and your Legislative Committee were senile old men, repudiated by their Association.

Your Legislative Committee is composed of four past presidents and a distinguished surgeon about their age. Your Committee needs no defense; its long and disinterested service makes it unnecessary. My only reason for calling your attention to this moronic correspondence is the terrible effect it has on the State Medical Association of Texas.

The following letter was dated March 9, 1945, and it was presumably widely circulated:

"My dear Doctor: Our own state legislative committee has sold us down the river in the matter of House Bill 314, the gist of which is discussed in the attached copy of an editorial by Don Weaver in the Fort Worth *Press*.

"For years, our contacts in Austin have been nothing more than inflammatory to our legislators, our own legislative committee has not been active, and we are fighting for our lives.

"Since the Chairman of our state committee will not even call his committee together in this grave crisis, we are going to work actively for his resignation. We must then bring pressure to bear to have an active committee formed, and in addition to this will have to have ample funds for a three year program which must be constructive.

"All of the county societies are calling immediate meetings for the purpose of getting an understanding of this situation and to raise funds for this three year program. This will require a contribution of ten dollars from each member, with a total of at least twenty-five thousand dollars as a goal.

"IF IT IS NOT WORTH TEN DOLLARS TO EACH MEMBER FOR PROTECTION FROM VICIOUS LEGISLATION AND THE ULTIMATE PASSAGE OF BILLS TO PROTECT US IN THE FUTURE, THEN THAT MEMBER HAS A LOW ESTIMATE OF HIS SITUATION.

"This is an emergency and requires immediate action. Make checks payable to CHAIRMAN OF TARRANT COUNTY LEGISLATIVE COMMITTEE, P. O. BOX 13, FORT WORTH 1, TEXAS.

"Frequent reports will be furnished each society, and you will be directed as to what pressure to bring on your respective members of your legislature.

"Sincerely yours

(signed) JACK FURMAN, M. D."

Who is Jack Furman, M. D.? I have never seen this gentleman in my life. He must be a member of Tarrant County Medical Society, and from his letter either the Chairman or a member of their Legislative Committee. "This is an emergency and requires immediate action. Make checks payable to Chairman of Tarrant County Legislative Committee, P. O. BOX 13, FORT WORTH 1, TEXAS." Gentlemen you can't mistake this language. It seems highly improbable that the officers of Tarrant County Medical Society were not aware of this letter. A medical society has the power to discipline a member. I have not heard that this has been done. If you will read your Constitution and By-Laws it clearly states your Board of Councilors, through its Chairman, has the power to revoke the charter of a county society. It is of little moment whether the Legislature at Austin believes your Legislative Committee is old and senile, but it is of major importance what they think of the State Medical Association. You are the people who are involved; you are the people who have been traduced, you alone.

This House of Delegates, representing the State Medical Association of Texas, can demand through its JOURNAL an apology for the acts of the Tarrant County Medical Society. Your state officers are entitled to this protection from you.

I am mindful of the fact that there are those who are pacifists by nature, who are willing to condone a vicious act in the interest of so-called "harmony." Why crucify a committee of men who have given their best throughout the years with such nonsense? I hope no friend of mine will be guilty of this today.

Gentlemen, as Chairman of the Legislative Committee, I want to say that San Antonio, my home town, in the last ten years has not lost a vote in the interest of medical legislation. Tarrant County has five members in the House of Representatives, and three of them introduced cult bills this last time. You cannot laugh that off. Does that look like I am selling you down the river?

How do you expect a Legislative Committee to accomplish anything with this kind of a letter being circulated? You are the people who are being misrepresented. This is a bad situation, and I hate to have the duty of calling it to your attention.

These five senile old men will soon be out of this picture. We will have to be. I have been a member of the State Medical Association for over fifty years. I have missed probably less than five meetings of the House of Delegates in that length of time. I have spent hundreds of dollars of my own money in fighting the battles of the State Medical Association, and have never wanted to be remunerated for loss of time or money. This letter signed by Jack Furman does not set very well with me. I believe I am entitled to a little more consideration. I believe that the State Medical Association is entitled to know these things. Your Legislative Committee is entitled to more consideration than that. The State Medical Association should see that we get consideration.

I can stand flat-footed and look at the end of the road. I am not afraid of the end of the road, either. The fact of the matter is, I had intended to tender my resignation at this time, but since it has been demanded, gentlemen, I do not think I will do it. (Applause.)

I never in my life have dodged an issue.

Members of the Legislative Committee are high class men. Reeves, Buie, Joe Gilbert, Kyle, there is not a one of you who would think either one of those men would sell you down the river. I do not believe you could get anyone in this room to agree that they would sell you down the river.

Dr. Connally's administration is the top when it comes to legislative accomplishments. This has really been the hardest year I have ever had. I have worn out a set of automobile tires running to Austin. I have done some good, probably.

That is the record.

Now, gentlemen, I don't want to see you do anything as drastic as disciplining a county medical society. Tarrant County has got lots of good doctors and good men, but gentlemen, they ought not to allow a few hot-heads to jump up and write that kind of a letter unless they do something about it. I hate to be insulted publicly and apologized to privately. This thing has gone all over the state, and probably there are many who would come to the conclusion that these senile old men ought to quit.

My time is up after this next year. I expect to quit then. But if you want me to quit now, I want to say to you in all frankness and all good humor in the world, it is entirely satisfactory to me.

I thank you. (Applause.)

On motion of Dr. A. R. Shearer, seconded by Dr. L. B. Jackson, the Committee was given a rising vote of thanks and confidence.

President Connally: The report is referred to the Reference Committee on Reports of Officers and Committees.

Dr. F. J. L. Blasingame, of Wharton, offered a resolution directing the Legislative Committee to have introduced in the next Texas State Legislature, the legislative program previously approved by the Executive Council and House of Delegates, including the Basic Science Law.

Dr. Blasingame moved the adoption of the resolution, and the motion was seconded by Dr. John T. Moore, of Houston.

President Connally: I would like to ask a Vice-President to take the chair long enough for me to say a few words.

Dr. R. G. Johnson, Vice-President, assumed the chair.

President Connally: This is a very important subject. I am referring to it in my report and I am asking that it be given some study.

Secretary Taylor: A point of order. Any discussion at this time is out of order. The resolution should go in the regular order to the Reference Committee.

Vice-President Johnson: The resolution will be referred to the Reference Committee on Resolutions and Memorials.

Dr. H. F. Connally, President, assumed the chair.

President Connally: Next will be the report of the Committee on Public Relations.

Dr. Merton M. Minter, of San Antonio, member of the Committee, then presented the report of the Committee on Public Relations, as follows:

REPORT OF COMMITTEE ON PUBLIC RELATIONS

Nov. 1, 1944 to May 1, 1945

Members of the House of Delegates will recall the very excellent report of the Committee on Public Relations presented to the last House of Delegates. That report embraced a comprehensive program and was the basis for an increase in annual dues voted by the House of Delegates from $9.00 to $20.00. It was not anticipated that the whole increase would be needed for the program, which was expected to cost somewhere between twenty and twenty-five thousand dollars, the remaining funds raised by the increase in dues being needed for the increased expenses of the Association in general caused by the war and inevitable inflation.

The Committee got under way with its program with the usual difficulties encountered in any new endeavor. On November 1, the chairman, Dr. C. S. Venable of San Antonio, tendered his resignation to the Board of Trustees, which was regretfully accepted. Dr. Venable had rendered outstanding services to the Association in the field of public relations, both during his term of office as president, preceding the annual session of the House of Delegates referred to, and during his chairmanship of the Committee which he accepted at the conclusion of his administration as president. With Dr. Venable's resignation, the decision was made to move the office from San Antonio to the Central Office of the Association at Fort Worth, both as a matter of economy and efficiency in administration, since all work of the Association would thus be dovetailed and all members of the staff could be utilized to better advantage, as needed. Dr. Walter Stuck of San Antonio, previously co-chairman with Dr. Merton Minter, also of San Antonio, during Dr. Venable's administration as president, and member of the Committee since, also resigned from the Committee because of pressure of other work, which made necessary a more or less complete reorganization.

Briefly, the Trustees reverted to the original plan of a five member committee, with the appointment of Dr. R. B. Anderson, Fort Worth, assistant secretary of the Association, as chairman, at least temporarily, and Dr. Frank Selecman of Dallas, to fill the vacancy caused by the resignation of Dr. Stuck. We would here commend the exceptionally fine services rendered by Dr. Stuck as a member of the Committee, and express regret that he felt it necessary to resign. The Committee is at present composed of Dr. R. B. Anderson, Chairman; Drs. Merton Minter and R. A. Miller, San Antonio; Dr. Walter A. Coole, Houston, and Dr. Frank Selecman, Dallas.

The following physicians, who had heretofore functioned throughout the state as members of the Committee, were retained by the Board of Trustees as sectional advisers to the Committee: Drs. W. A. Smith, Beaumont; H. H. Cartwright, Breckenridge; Harry G. Heaney, Corpus Christi; Felix P. Miller, El Paso; R. J. White, Fort Worth; Phil A. Bleakney, Harlingen; Ruby Lowry, Laredo; Allen T. Stewart, Lubbock; V. E. Schulze, San Angelo; William Hibbitts, Texarkana; C. G. Catto, Waco; O. B. Kiel, Wichita Falls, and Sam Key, Austin.

It will be recalled that the by-law creating this Committee provided that the Board of Trustees and the Board of Councilors would serve as advisory groups with the Committee, directly under the supervision of the Board of Trustees, to which group this report is made.

To broaden the function and activity of the Committee, the Trustees added the Council on Medical Economics and the President and President-Elect as further advisers.

Shortly after the reorganization reported here, the Committee formulated a tentative program, and at its request, President Connally called a meeting of the Executive Council at Fort Worth, December 3, to consider this report. The program as presented was enthusiastically adopted, and a summary thereof was published in the December, 1944, JOURNAL, page 404.

After the office of the Public Relations Committee, with its files, supplies, etc., were moved to Fort Worth, some time was required for the establishment and organization of an efficiently functioning staff. Most of this work was accomplished under the direction of Mr. Jeff L. Reese, for many years director of Public Relations for the Association. Unfortunately, during the month of December, 1944, Mr. Reese's time was badly needed for preparations for the Forty-ninth Session of the State Legislature, which convened early in January. After Mr. Reese left for Austin for attendance on the legislative session, as is required of him, the work of the Public Relations office became more difficult of execution because of a new staff, and the added public relations administrative details with which the staff was not fully acquainted. It was also necessary to employ a new public relations counsel, which would be more available to the Committee at its office in Fort Worth. The firm of Aniol and Auld had served the Committee well in San Antonio. A good deal of time was taken in the selection, as it is believed that the success of any public relations program would depend more upon the character and ability of the counsel selected to direct it than upon any other single feature. The Committee finally employed the firm of Watson Associates, Dallas, after extended investigation and deliberation. Mr. Philip Fox, of this firm, who will serve principally as counsel for the Committee, had previous committments and contracts and was not able to give the full value of his counsel and time until about April 1. Since that time, Mr. Fox has been actively orienting himself in the needs of medicine, as far as public relations in Texas, especially, and the nation, generally, are con-

cerned. He has visited and conferred with a number of physicians in various parts of the state. We might add that Mr. Fox is also personally interviewing editors of leading newspapers of the state, regarding their attitude toward socialized medicine.

In spite of the numerous difficulties encountered by a reorganized committee, in the middle of an administration, and with an unusually hectic legislative session imposed upon its program, news letters giving concise reports on medical legislation and other matters in which Texas medicine is particularly interested, have been issued periodically to the entire membership of the Association. These news letters have appeared oftener than once a month, on the whole.

Factual news releases on medical affairs have been released to the news services in Texas, Associated Press, United Press, etc., through the public relations counsel, on all matters that were considered of news value. These have received satisfactory publication, as revealed by clipping services.

Material has been furnished from the Library of the Association to speakers throughout the state, on the subject of socialized medicine. To date, there has not been an intensive effort made to utilize a speaker's bureau, as was done during the last session of Congress, in opposition to the Wagner-Murray-Dingell Bill. The reason for not doing so is that, so far, Senators Wagner and Murray have not introduced their bill in the new Congress. They have repeatedly stated that it will be re-introduced, but that it will be revised to meet the critical opposition it received in the last session. Representative Dingell has re-introduced his bill in the House of Representatives in the same form as it was last year, but he has stated, also, that it will be amended. The Committee has been waiting until it is believed that the most effective results can be accomplished by a campaign in opposition to these measures.

A highly satisfactory radio broadcast program of the health transcriptions furnished by the American Medical Association has been conducted throughout Texas, during the last several months. This program was initiated by the Committee just before the office was moved from San Antonio to Fort Worth, and some difficulty was experienced in picking up loose ends, determining not only which stations had the records, but the status of the programs in progress. The Committee has endeavored to publicize these broadcasts as widely as possible by asking doctors in the coverage area of each station to have their patients listen in. Actually, it is believed that the state has been fairly well covered. The following stations have used these broadcasts:

KTBC	Austin
KRIC	Beaumont
KBWD	Brownwood
KSAM	Huntsville
KFRO	Longview
KNET	Palestine
KIUN	Pecos
KVOP	Plainview
KGKL	San Angelo
KTEM	Temple
KGKB	Tyler
WACO	Waco

Three sets of records are being used, as furnished by the Bureau of Health and Public Instruction of the American Medical Association, as follows: "Before the Doctor Comes," consisting of 16 transcriptions; "Dodging Contagious Diseases," 12 transcriptions; and "Medicine Serves America," 10 transcriptions. The broadcasts are either sponsored or on a sustaining basis, at the pleasure of the stations, but sponsors have been almost universally used. It is required that any commercial announcement used in connection with the broadcasts be approved by the county medical society where the station is located. In two instances, difficulty has been experienced in connection with undesirable commercial announcements publicizing proprietary products not approved by the medical profession, but these difficulties have been due, we are sure, to misunderstanding or lack of appreciation of the significance of endorsement of such products by the medical profession. Our Committee is dependent upon the aid of local county medical societies in solving these problems, and without such assistance they cannot be satisfactorily solved. On the whole, the radio programs may be said to have proved popular with the public, and we consider it of great public relations value for medicine. We would urge its continuance and extension in the future as facilities are available.

It will be recalled that prior to the raise in dues, donations were received and encouraged by the Board of Trustees from individual members, county societies, or whoever wished to contribute to the cause. After the raise in dues it was thought that this means of financing a program should be sufficient and contributions were no longer solicited. However, we should report that a donation of $15.00 to the public relations fund has been accepted from the Lubbock-Crosby Counties Woman's Auxiliary, which earnestly desired to be helpful. Appreciation is hereby expressed, not only for the money, but for the spirit manifested in the matter.

It will be recalled that the House of Delegates approved a proposed program of public relations that would have cost the Association from $20,000 to $25,000 if it had been carried out as planned. Because of difficulties referred to in this report, it has not been possible to prosecute the public relations program as originally planned. As a matter of fact, at the time this report is prepared, the Committee has expended, roughly, from $7,500 to $8,000 in public relations work since the House of Delegates last met. If it had been possible to put the program into immediate execution as planned, it would no doubt have cost from $20,000 to $25,000. It is estimated that the increase in dues voted by the House of Delegates, amounting to $11.00 for each regular member, would have made available to the Public Relations Committee the money necessary to put on the type of program that the Association should have.

Reference is made to cost of the program and what may be accomplished, in connection with what should be the plans for the ensuing year. While your Committee is not at all satisfied with what has been accomplished to date, it believes that since a highly qualified public relations counsel has been employed, and is now in a position to direct the program, the Association should by all means prosecute it with full vigor from this point on. Medicine definitely needs to be placed in a better light with the public, and the public needs to know what private medicine has to offer as contrasted with what the public will get if the socialization of medicine should come to pass. Public Relations is inevitably wrapped up in what we refer to as politics. If we carry out our obligation to the public as the only group qualified to serve as the guardian of the public health, we cannot avoid being in politics. We would urge the strongest possible so-called political program to insure the election of a Legislature and Congress that will have the right attitude toward public health and medical practice, all for the good of the public and not, as is too commonly thought, for the selfish motives of the medical profession.

There has been some discussion as to whether or not this Committee should be appointed by the Board of Trustees and be directly responsible to that group, as provided for in the By-Laws, or whether the Committee should be elected by the House of Delegates and be responsible directly to that body. It is im-

material to the members of the Committee as to how it shall be appointed or directed, although it has appreciated the value of the present arrangement and the ready availability of the wise counsel of the Trustees. The original thought in the creation of the Committee, as pointed out in the last report of the Committee on Public Relations, was that a continuity of policy and objectives might be more successfully attained if the Committee were appointed by the Board of Trustees, instead of a constantly changing personnel, and change in programs with each administration; and that, because its operation involves the expenditure of comparatively large amounts of money, it should be directly under the supervision of the Board of Trustees. We point out these factors for the consideration of all concerned.

Report of Public Relations Committee
May 1, 1945 to May 1, 1946

This, the second section of the report of your Public Relations Committee, covers activities for the past twelve months. The committee has carried forward a very definite program with the view of making the general public fully acquainted with the problems of the medical profession in Texas, and bringing it to a closer understanding of such problems.

A great part of the activities of the committee has been in combating, in every manner possible, the proposed federal legislation which seeks to socialize American medicine. In accord with the wishes of the Legislative Committee of the State Medical Association, Public Relations Committee members have publicized throughout Texas the danger to the public health and welfare inherent in both the Wagner-Murray-Dingell bills and the Pepper bill, both of which have been disapproved by the Executive Council of the State Medical Association. Similarly, they have disseminated information in regard to legislation which is approved by the State Medical Association, such as the Hill-Burton Hospital Construction bill and the Scientific Research bill (Magnuson Bill). The Public Relations Committee has also endeavored to keep both the physicians and the public of Texas fully advised in regard to state legislation.

In opposition to the Wagner-Murray-Dingell bills, the Public Relations Committee had printed and circulated pamphlets which received wide distribution throughout Texas at the hands of the membership and their friends. The circulation of these pamphlets, opposing socialized medicine, numbered about 400,000.

The Public Relations Committee also arranged and paid for two radio addresses by distinguished Texas laymen over statewide radio hook-ups. In order to assure the widest possible listening audiences, these addresses were advertised in advance in the larger newspapers of Texas. The first address was made by Mr. Walter W. McAllister, prominent San Antonio businessman, and the second address was made by Mr. R. L. Thomas of Dallas, member of the Board of Regents of the State Teachers Colleges of Texas. Both addresses were commented upon favorably by the press throughout the state.

The Public Relations Committee has also sent to the newspapers of Texas a large number of articles concerning federal legislation and other subjects in which the physicians and the public of Texas have a mutual interest. These articles have been very well received and extensively used. Favorable editorial comment has resulted in all sections of the state. The clippings returned from the various newspapers indicate an increasing interest on the part of the public in medical problems generally, and also a substantial and general growth of opposition coming from all classes of citizens to the proposed federal control of medicine.

During the past six months several hundred advertisements opposing federal control of medicine have appeared both in the daily press and the weekly press of Texas. The Public Relations Committee consulted with the various advertising agencies promoting such advertising and aided in drafting these advertisements so that they should appear in more or less uniform style. The cash value of these advertisements would reach a staggering total, and they are continuing throughout the state—in fact, they will continue to be used generally just as long as federal medicine is an issue before the Congress. Several advertising agencies are at present handling these advertisements, and all of them are in close contact with the Public Relations Committee, which is thus enabled to suggest changes in the types of advertisements as may be found necessary during the progress of the legislation in Washington. The Public Relations Committee feels that these advertisements have done much to awaken the people of Texas to the tax burden which they will have to assume, and the disruption of medical service which they will face, should these federal bills become laws.

The Public Relations Committee has received the full coöperation of the National Physicians Committee of Chicago, and has consulted personally, on numerous occasions, with the Chairman of such committee, and its executive manager. The National Physicians Committee is devoting its full time and energy to fighting the Wagner-Murray-Dingell bills.

The Public Relations Committee is also active in the operation of a speakers bureau for the purpose of promoting addresses in opposition to federal control of medicine throughout Texas. A complete speakers kit, carrying speeches prepared by the Public Relations Committee and detailed information of all kinds in regard to proposed federal legislation, has been prepared and is kept revised and up-to-date. In this manner material is instantly available for any speaker, whether layman or physician, who has a speaking date. Meetings of civic clubs, women's organizations, and other gatherings, have been addressed in all sections of Texas.

The Public Relations Committee has sent approximately 3,000 pamphlets and reprints to speakers, both physicians and laymen. As a result, a large number of organizations hearing them have promptly passed resolutions condemning federal medicine, and forwarded them to the members of Congress from their respective districts.

The Public Relations Committee has attempted to keep in close personal contact with the various county medical societies throughout Texas. Dr. R. B. Anderson, usually accompanied by some other representative of the committee, has spent weeks traveling over Texas and meeting with committees of the various societies and addressing membership meetings of the societies. He has explained the program of public relations work, has discussed the political situation in regard to state legislation for the benefit of public health and welfare, and also in regard to the federal bills pending in the Congress. He has received the warmest kind of support and coöperation from county medical societies, and the Public Relations Committee believes that much better and coördinated effort may be established through such personal visits than by the writing of letters.

Evidencing the scope of Dr. Anderson's work in behalf of the Public Relations Committee, he visited 13 out of the 15 Councilor's districts of the State Medical Association. He visited 46 different medical societies, embracing 91 counties. He visited each of the 31 Senatorial Districts of Texas, and traveled the state from Amarillo to Laredo and from Beaumont to Lubbock, purposely selecting legislative districts in which state legislators have

been found opposing measures advocated by the State Medical Association. In the territory covered there were 91 State Representatives. Of this number, 70 have been opposed to measures favored by our Legislative Committee, while 21 have supported such measures.

The Public Relations Committee has, during the year, sent to the doctors of Texas numerous special news letters advising them of legislation and of other matters affecting their interests. These news letters have not been mailed unless the committee had something important to announce, and they have in all instances been made as brief as possible.

Since the Executive Council of the State Medical Association passed resolutions favoring voluntary prepaid medical and surgical insurance meeting the standards set up by the Council on Medical Economics and the American Medical Association, the Public Relations Committee is making a sustained, coördinated effort to inform the public through the press and other media, of the desirability of voluntary health insurance of this type rather than compulsory federal health insurance. This campaign is now in progress and will be continued indefinitely.

The Public Relations Committee has during the year striven to establish contact with other organizations, such as hospitals, dentists, nurses, druggists, and so forth, which are opposed to federal medicine. Many of these contacts have been made mainly through the local medical societies, and these organizations have aided in distributing literature opposing such proposed federal laws, and are actively opposing such laws.

The Public Relations Committee has continued the series of public health educational radio programs over the smaller stations of the state with the endorsement of the various county medical societies in the territory. These programs come as recordings made available by the American Medical Association. They are either paid for by local business interests with the sanction of the local county society, or are carried on a sustaining basis by the individual stations.

The Committee at present has on hand six series of health talks. There have been sixteen stations which have broadcast the health talks during at least part of the year. Nine are now broadcasting to a potential listening audience of several million Texans. To date twelve stations have broadcast the series "Before the Doctor Comes." Ten of the above stations have completed broadcasting the series "Dodging Contagious Diseases." Nine of the above named stations have completed broadcasts of the series "Medicine Serves America." Since this is a war series, it has been discontinued. Four of the above stations have completed the series "Keep Cool," which is only for broadcasting in the summer. Eight of the above stations have completed the series "More Life For You." Four of the above stations have completed the "Guardians of Your Health" series, with five to broadcast later. Four of the above stations have completed the "Live And Like It" series. Seven of the above stations have broadcast the "Why Do You Worry" series. During the past year one station has been added to the list of those coöperating, namely, KTSM of El Paso.

The Public Relations Committee has also coöperated with the Memorial Library Committee of the State Medical Association, and publicity concerning the Library Committee's campaign has resulted in a considerable augmenting of the Library Fund. This campaign is now in the process of being extended in its scope, and during the next few months every effort will be made to secure a fund sufficient to undertake construction of this tremendously valuable research institution.

Realizing that politics have been thrust upon the profession by interests which would gladly see the private practice of medicine either destroyed or crippled by unfriendly federal and state legislation, the Public Relations Committee has devoted much time to this subject. The present congressional delegation from Texas has, with hardly an exception, gone publicly on record as being opposed to socialized medicine and the regimentation of doctors by the government. However, a number of the friends of medicine in the Congress are not seeking re-election this year. Some of the present candidates for Congressional offices are heartily in favor of socialized medicine. The Public Relations Committee, through personal visits and by letter, has urged, and is still urging, all county societies actively to support the friends of organized medicine in the summer campaigns. The best service that Texans can render in opposition to socialized medicine is the sending of Congressmen to Washington who will cast their votes against it.

The Public Relations Committee in March invited 108 physicians representing all Congressional Districts in Texas, to a group study meeting in Fort Worth. This meeting was devoted to a full study of the Wagner-Murray-Dingell bill, and a discussion of the existing Congressional situation throughout Texas. The state situation was similarly discussed, and the Public Relations Committee has been urging county medical societies to take an active interest in the campaigns for the state legislature this year. The Public Relations Committee has coöperated with the Legislative Committee in seeing that information as to the records of all State Legislators and Congressmen are placed in the hands of county societies, with the request that they become active in the matter.

Knowing that without a maximum voting strength, the physicians of Texas and their friends would be powerless in congressional and legislative races during the summer, the Public Relations Committee last fall instituted a statewide "Pay Your Poll Tax" campaign. The county societies were urged to appoint special committees to see that all their families, employees, patients, and friends who were opposed to socialized medicine and who wished to see some constructive public health legislation made effective in Austin, pay their poll taxes. Organizations with similar aims were also contacted, and the Woman's Auxiliary of the State Medical Association and the Woman's Auxiliaries of the various county societies took an active part in the poll tax drive. The results were impressive, and the effort has resulted in many thousands of Texans qualifying to vote for the purpose of supporting candidates opposed to socialized medicine. A newspaper release, widely printed through Texas, called attention of the public and candidates to the fact that the physicians of Texas were well prepared to support their friends this year.

The Public Relations Committee has used its best efforts to aid physicians returning from the service in reëstablishing themselves. A representative of the Public Relations Committee visited the various medical colleges in Texas in order to aid in publicizing their postwar programs in behalf of returning physicians. A standard advertisement was prepared and sent to the various county medical societies in which the return of the physicians from the service could be announced to the public. Many societies availed themselves of this advertisement.

Drs. R. B. Anderson and Merton M. Minter, of the Public Relations Committee, attended the meeting of the Council on Medical Service and Public Relations of the American Medical Association at Chicago last winter. Their suggestion that the American Medical Association augment their public relations work, as has been done in Texas, by the employment of professional public relations counsel, has been adopted and put into effect by the national organization. The Public Relations program in Texas

was discussed at the meeting and won commendation.

Dr. Merton M. Minter, member of the Committee, and Dr. F. J. L. Blasingame, Wharton, Councilor of the Eighth District, attended a special meeting at St. Louis, for the study of the Wagner-Murray-Dingell bills, and the study group meeting in Fort Worth was modeled along similar lines.

Advance and current publicity for the 1946 annual session of the State Medical Association of Texas, has been handled by the Public Relations Committee.

The coming year, 1946-47, finds the Public Relations Committee in the thick of the fight against federal medicine and to secure unbiased and unprejudiced representation at Austin. The program now in operation should be extended and intensified.

Respectfully submitted,

R. B. Anderson, Chairman,
Merton M. Minter,
R. A. Miller,
Frank Selecman,
E. Trowbridge Wolf.

President Connally: The report will be referred to the Reference Committee on Medical Service and Public Relations.

The report of the Committee on Cancer, Dr. E. W. Bertner, Chairman.

Dr. E. W. Bertner of Houston, Chairman of the Committee on Cancer, then presented the report of the Committee on Cancer, as follows:

REPORT OF COMMITTEE ON CANCER

Up until the time of preparation and passage of House Bill 268, creating the State Cancer Hospital, in 1941, the Cancer Committee of the State Medical Association had not been very active. In fact, the first major activity of the Committee was the sponsoring of that legislation. The Committee was in large measure responsible for the educational activities which demonstrated the need for such legislation, and enlisted the support of the legislators. The Committee cannot refrain at this time from paying tribute to the progressive foresight, the zeal, and the unselfish efforts of Arthur Cato, to whom should be given full credit for the passage of this important measure.

With the enactment of the enabling legislation, the Committee turned its attention to measures of coöperation in the setting up of plans for putting the program into effect. These efforts came to fruition with the dedication of the M. D. Anderson Hospital for Cancer Research on February 17, 1944, at ceremonies attended by prominent citizens from all parts of the State, and by visiting physicians and scientists of international renown.

Meanwhile there had been organized in Texas a branch of the Field Army of the American Cancer Society. This group also was not very active, at least by comparison with similar groups in the other states of the union. They assisted greatly in the activities which resulted in the passage of the Cancer Act, and conducted a modest program of popular education on the subject of cancer, directed largely towards the women of the state.

What should prove to be an important part of the activities of this Committee during the past year has been its work with the American Cancer Society. This national voluntary agency is just completing a program of reorganization and expansion of activity which will permit it to make effective contributions toward (1) education, both public and professional, (2) service to the cancer patient, both professional and by trained volunteers under professional supervision, and (3) research. The last named activity is under the immediate and constant supervision of the National Research Council of the National Academy of Sciences.

The plan of organization now being completed provides that the actual policy-forming control of the Society shall be vested in the hands of directors who are to be elected by the representatives of duly constituted state divisions. Your Chairman has been authorized by the American Cancer Society to act as its representative in reorganizing the activities of the Society in Texas to the end that this state may have an organization eligible to be accepted by them as their Texas Division.

It is the announced policy of the national organization to seek what they term "three pronged" leadership: first, the medical profession, whose members will be responsible for all of the medical aspects of the Society's program and who will assist in the formulation of the general policies and programs of the Society and its state divisions; second, leaders in commerce and industry, whose chief responsibility will be to help secure the funds necessary to carry on the program and to provide continuing, year-'round supervision to make certain that the contributed funds are wisely and economically administered; and third, a group of social, civic, and political leaders, both men and women, who will secure and furnish the voluntary assistance which is so important in many aspects of the program.

In addition to these general policies, it is specifically stated that all projected activities which would bring the Society or its state division into direct contact with the cancer patient must have prior approval of the medical society having jurisdiction in the county where the proposed activity is to be conducted. This program has been approved in principle by the American Medical Association. It will be rigidly adhered to by the Texas Division.

The Texas Division of the American Cancer Society desires the fullest possible measure of medical leadership and control. It wants this leadership to come as far as is practical from the organized medical profession of the state, as represented by the State Medical Association of Texas, with its component county medical societies. It hopes that this leadership will be derived from physicians who are recognized by their associates as having special competence in the field of cancer control, who have a sympathetic interest in the work and the program of the American Cancer Society and of its Texas Division, and, finally, who are truly representatives of the several sections of the state, and who will give continuing assistance to the division on something more than a temporary, or year-to-year basis.

To accomplish these objectives the following method of organization is proposed. There will be constituted a Board of Directors of not more than sixty persons. For purposes of organization, the original board will be largely appointive; as rapidly as possible this method will be replaced by a system of election on a just and democratic basis. These directors will be selected on three bases as follows:

Representative Directors.—In each of the fifteen councilor districts of the State Medical Association, there will be selected a physician and a lay person, either men or women. When the organization is completed, these directors will be selected by vote of the members of the Cancer Society who live in the district.

Directors at Large.—A second group of fifteen directors will be elected upon the nomination of the Dean of Baylor University College of Medicine, the Dean of Southwestern Medical College, and the Dean of the University of Texas Medical Branch. These deans will be invited to become a committee for the purposes of naming these directors and their successors as their terms of office expire.

An important function of the Directors at Large will be to constitute the Committee on Projects and Allocation of Funds. It shall be the duty of this committee to pass upon all projects submitted by local

units of the Division which require the appropriation of funds, and to advise with the Executive Committee as to their disposition. The deans will be asked in nominating these directors to pay reasonable attention to their geographic distribution. It is hoped that through the efforts of this committee the Division can make certain that its funds are wisely and equitably distributed for the best interests of the people of the state.

Official Directors.—A third group not to exceed fifteen directors shall be invited to serve on the basis of their holding some official position with an organization or agency having a logical interest in the cancer control problem. To serve as directors in this group will be invited such people as the president of the State Medical Association of Texas, and the chairman of its Cancer Committee; the president of the State Dental Society; the president of the State Nurses Association; the president of the State Public Health Nurses Association; the president of the State Hospital Association; the director of the M. D. Anderson Hospital for Cancer Research; the Dean of the University of Texas Medical Branch; the Dean of the University of Texas School of Dentistry; the Dean of Baylor University College of Medicine; the Dean of Southwestern Medical College; the Chairman of the State Boards of Health, Education, and Welfare; the State Health Officer.

The Directors thus described will constitute the policy-making body of the Division and be the trustees of its assets. At all times a majority of the Board of Directors will be physicians who are accredited members of the State Medical Association of Texas. To provide a flexible and workable group for the administration of the routine of the Division, the Directors will elect an Executive Committee and will also elect the officers of the Division.

Medical Advisory Committees.—In addition to other necessary committees there will be constituted a Medical Advisory Committee which will be charged with the responsibility of advising, guiding, and directing the medical activities of the Division.

The Medical Advisory Committee shall consist of the following: (a) all members of the Board of Directors who are engaged in the clinical practice of medicine or of dentistry; and (b) one additional physician from each of the fifteen councilor districts of the State Medical Association.

These additional members will be selected on a basis and after a method recommended to the Division by the State Medical Association, or they shall be appointed by the Council of the Association. It is hoped that of the two physicians from each councilor district, one will always be the councilor of that district, who will serve either as a member of the Board of Directors of the Division, or as a representative of the district on the medical advisory committee.

Your Committee feels that the members of the State Medical Association will be interested in knowing the identity of the group of people now engaged in organizing this work: Mr. Tom Braniff, President of the Braniff Airlines, is to serve as Chairman of the Board; Mr. Frank C. Smith, President of the Houston Natural Gas Corporation, will serve as President of the Division; E. W. Bertner, M. D., who has been appointed by the American Cancer Society to serve as Chairman of the Executive Committee, will also serve as Vice-President of the Division; Mr. E. L. Flippen, President of the First National Bank, Dallas, is now serving as Treasurer of the Division; Mrs. Oveta Culp Hobby, of Houston, will serve as Secretary (she has also been appointed by the American Cancer Society to serve as State Commander of the Field Army, and will organize the volunteer workers of the Division); Col. Ike Ashburn, President of the Todd-Houston Shipbuilding Corporation, is Chairman in charge of the current campaign for funds; Mr. J. Louis Neff has been appointed Executive Director of the Division. Until April 15, Mr. Neff occupied a similar position with the American Cancer Society, and prior to that served for many years as the Executive Secretary of the Nassau County (N. Y.) Medical Society.

Your Committee seeks approval by the State Medical Association of this important activity; but more than that, it seeks the approval and earnest support of every physician in the state of Texas. The Division in turn pledges that all of its activities will be planned for the best interests of the people of Texas, of the cancer patients of the state, and of those who are logically responsible for their care.

Respectfully submitted,
E. W. Bertner, Chairman,
George T. Caldwell,
Frank C. Beall,
A. A. Ross, Jr.,
Dudley Jackson.

President Connally: The report is referred to the Reference Committee on Scientific Work.

The report of the Committee on Fractures was then presented by the Secretary, as follows:

REPORT OF COMMITTEE ON FRACTURES

We wish to emphasize those well known principles in the care of fracture cases, viz., early debridement and wide dependent drainage of compound fractures, with penicillin to the limit and early reduction with proper fixation in all cases.

Respectfully submitted,
Charles E. Collins, Chairman.
Julius T. Krueger,
Earl H. Newton,
Joe B. Foster,
William M. Gambrell.

President Connally: The report will be referred to the Reference Committee on Scientific Work.

Dr. Holman Taylor, Chairman, then presented the report of the Committee on Procurement and Assignment, as follows:

REPORT OF COMMITTEE ON PROCUREMENT AND ASSIGNMENT

May, 1944, to May, 1945

Contrary to an opinion which seems to be generally held that the work of Procurement and Assignment has been practically completed, the demands made on Procurement and Assignment at present are about as burdensome, if not more so, as ever before. The character of the work has changed in many particulars. Now a great deal of statistical information must be compiled each month and sent to Washington by the State Office. These data are no doubt essential to the needs of the Washington Office, and since the government pays the salaries of the clerk-stenographers to prepare them, we have done our best to meet the requirements.

Selective Service is constantly making inquiries regarding the status of physicians in accordance with its regulation that local boards review the status of their registrants each six months, since they cannot defer a registrant for a longer period than that without re-appraising his classification. Added to these inquiries, all of which must be answered promptly, is the voluminous correspondence regarding deferment of hospital residents. The State Office of Procurement and Assignment is the liaison, or clearing station, between Texas hospitals and Washington, on quotas allowed for house staffs and deferments of commissioned residents; between local procurement and assignment committees and/or physicians themselves and Selective Service; between communities and local procurement and assignment committees and/or medical officers, and the Washington Office regarding release of med-

ical officers to return to civilian life, where critical shortages exist. These facts are mentioned not to complain but perhaps to explain why some errors occur in the voluminous detail connected with the work.

The set-up of Procurement and Assignment in Texas has not changed since our last report. Dr. Holman Taylor is chairman, Dr. R. B. Anderson is vice-chairman, and Dr. S. E. Thompson of Kerrville, chairman for the Eighth Service Command, covering several other states besides Texas. The State Advisory Committee, in addition to Drs. Taylor and Anderson, includes Drs. G. F. Thornhill, Austin; E. F. Cadenhead, Brownwood; C. G. Swift, Cameron, and J. S. McCelvey, Temple. The State Office has used the Advisory Committee in consultation in difficult cases. The State Office leans heavily upon and depends upon recommendations made by the 126 local procurement and assignment advisory committees throughout the State, and a large part of the credit for the successful operation of Procurement and Assignment Service is due to the fidelity to service of these committees, rendered without hope or expectation of reward. Comparatively few changes have been made in local procurement and assignment committees since our last report. Most of these changes were to fill vacancies caused by death or entry of the members into the Armed Services. Replacements were made in each instance on the nomination of the county medical society concerned, the appointment being made by the Office of the State Chairman.

In one instance, because of the development of complete disagreement of a local committee with its chairman, where an impasse was reached with regard to the procurement and assignment status of a physician in that area, it became necessary to ask the entire committee to resign, so that the county medical society might make nominations for a new committee. We are pleased to report that the situation has been satisfactorily composed through the coöperative resignation of the old committee and the prompt appointment of the nominees of the society.

As the war drags on, and death takes its toll of the older doctors at home who are overworked, more and more communities in Texas are becoming acutely short of medical care. In fact, we cannot report, as of last year, that there are no communities now in which medical care shortages exist that we have not been able to relieve by relocation of physicians. It is sincerely hoped that with the anticipated climax of the European War, some medical officers may be released to return to civilian practice in these areas. The necessary appeals, properly supported, have been made to Washington, and they will be granted as the exigencies of the services permit.

We reported last year that we had not used the provisions of Public Law No. 216, which provided federal funds for relocation of physicians. We had not found it necessary to do so. Time has proven that the law was not the answer to the problem, and Congress did not provide appropriations for its extension. Funds are no longer available for relocation.

The same difficulties in shortages of physicians have been experienced in industry. Dr. Jack Furman of Fort Worth, as chairman of the Committee on Industrial Health of the State Medical Association, has continued his aid to Procurement and Assignment Service in securing physicians for industry.

There has been little change in the 9-9-9 program of deferment of commissioned medical officers by the Surgeons General, through coöperative agreement with Procurement and Assignment Service, except that the Directing Board of Procurement and Assignment has increased quotas of house staffs allotted to Texas hospitals to the extent that they could, in response to our requests for such increases. The difficulty has been that hospitals have not been able to find a sufficient number of physically disqualified interns and residents for the required ratio in their quotas, and have had to depend on too large ratios of deferred commissioned officers. The Armed Services cannot permit the number of deferments that are needed, which is causing a real burden to hospitals in rendering proper hospital care.

Despite the shortages referred to here, both in medical care by civilian practitioners, and in hospital care by hospital residents and interns, on the whole the public of Texas has not suffered too greatly. The worst feature has been the increased strain placed upon doctors, principally in rural areas, but also in urban centers.

No solution has yet been found of the problem of the three class-A medical colleges in Texas, in securing the deferment of commissioned officers as instructors and demonstrators, to which reference was made in our report of last year. In spite of that, our college faculties have functioned with splendid success in continuing to turn out well-educated graduates in the accelerated program that was the result of the war emergency. These faculty members are deserving of the highest commendation for their efforts.

During the past three months, Procurement and Assignment Service has done everything possible to meet the critical need of the Navy for medical officers. Local procurement and assignment advisory committees have been repeatedly requested to reappraise their areas in an effort to make available every physician of appropriate age for service, who could be spared without too greatly jeopardizing community medical care. It has not been possible to furnish many additional physicians for the Navy from Texas, for the simple reason that this State has already furnished the Armed Services with about all the qualified physicians it can spare. Efforts to find more available physicians are being continued and will be continued until the emergency has passed.

Since our last report, the reverse condition is true with regard to the Army, which is not now commissioning physicians from civilian practice. The Army is depending solely upon the addition of commissioned interns and residents, as they complete their hospital service.

About March 10, 1945, the State Chairman's Office was informed of a change in Selective Service regulations, requiring that occupational classification forms be executed by every physician in Texas, within Selective Service age brackets (under 38 years), who was classified 2-A or 2-B on January 1, 1945, and who is considered essential by Procurement and Assignment. April 1 was the deadline, which was impossible to meet. Different forms were required for physicians under 30 and those from 30 to 37, inclusive. Forms were sent to each physician in Texas, in accordance with recommendations of local procurement and assignment committees as to their essentiality. This change in Selective Service regulations has greatly increased the work of the State Office.

It has never been clear whether physicians who have been rejected for commissions or physicians who have received medical discharges from the Armed Services need to be thus certified. However, it is the only procedure by which Procurement and Assignment can be definitely certain that a physician is protected from induction as an enlisted man, since the physical standards are lower than for a commissioned officer, and a physician rejected for a commission might pass a pre-induction physical examination for a private. For that reason, Selective Service occupational classification forms have been certified for physicians who have been re-

jected for commission when they were sent in as requested by the State Office. Unfortunately, the entire procedure has been misunderstood, and severely resented in some instances. It is not believed that local Selective Service boards would induct such physicians as privates, but they have it within their power to do so if the physician qualifies physically and has not been certified as essential by Procurement and Assignment, according to the prescribed regulations.

May, 1945, to April, 1946

Since our last report, prepared for the House of Delegates meeting in May, 1945, cancelled because of war conditions, Procurement and Assignment Service for Physicians for Texas has undergone many changes. Until V-J Day, the Navy was continuing to scrape the barrel for medical officers, which they sorely needed at the time. But few could be furnished from Texas since the State had already contributed all or more than it could spare to the Armed Services without seriously crippling medical care to civilians. The advent of V-J Day promptly stopped the commissioning of medical officers by the Navy. The Army had stopped taking officers from civilian practice some time before, as stated in our last report.

Between May, 1945, and V-J Day, Procurement and Assignment Service had been successful in securing the releases of some medical officers from the Army to relieve critical medical care shortages, principally in rural areas of Texas. After V-J Day, this activity steadily increased and through the services of Procurement and Assignment Service, releases of some three hundred medical officers were secured to relieve acute medical needs of the civilian population, principally in rural areas and small towns, though a number were secured for cities. A still greater number have been released on points.

Beginning with the November, 1945, number of the Journal, the names of medical officers returning to Texas have been published in that and the several subsequent issues, giving such data as branch of service, county, previous location, present location, and approximate date of release as far as known. Each returning officer has been communicated with, welcomed back to civilian practice, and requested to furnish a biographical sketch of his record of service from the date he entered until he was separated therefrom. A photograph has also been requested. All of these data will be carefully preserved in the personnel files of the Association. We are pleased to report that medical officers have responded splendidly to these requests, and valuable biographical files of members who served in World War II are being compiled in the offices of the Association. To date the names of 1,085 medical officers returning to Texas have been published, and the publication of these names and the data given with them will be continued until all are returned.

After V-J Day, the functions of Procurement and Assignment Service have largely been (1) that of helping to secure the release of medical officers from the Armed Services to meet critical civilian needs; (2) the rendering of services in connection with the deferment of commissioned medical officers serving internships and residencies in hospitals under the so-called 9-9-9 program; and (3) helping returning medical officers find suitable locations. In this connection, extensive card files have been built up on the professional qualifications of returning medical officers seeking locations where they are needed, and of places needing physicians. All of these files are being taken over by the State Medical Association, as will be referred to later in this report. These functions are properly those of the Association in coöperation with the county medical societies.

Under date of November 5, 1945, the Central Office of Procurement and Assignment Service, Washington, issued a directive to all State Chairmen, advising that the 9-9-9 program would be converted to a peacetime basis as rapidly as possible, and complete directions were given to pass on to hospitals for their guidance in the matter. A complete discussion of the reconversion program was published editorially in the December, 1945, number of the Journal[1], which editorial is made a part of this report. Suffice it to say here that the purpose of the program was to replace commissioned medical officers serving as residents with returning veteran medical officers as rapidly as possible, so that the latter might not only be released from the duties of war they had patriotically, gloriously and effectively performed for their country, but that they might refresh themselves with hospital work before returning to their former civilian practice. The reconversion program was largely completed on April 1, 1946, on which date all Texas hospitals participating in the program were informed that from that date on all matters pertaining to the deferment of commissioned medical officers serving internships and/or residencies should be taken up directly with the Office of the Surgeon General of the branch of service concerned.

Opportunity was taken at this time to express to hospital administrators, hospital medical directors, and intern and resident staff committees very great appreciation for their fine coöperation throughout the operation of the 9-9-9 program during and after the war, and during the reconversion period.

For the purpose of completing the record of Procurement and Assignment Service, mention is made here of its transfer by Executive Order, October 12, 1945, from the War Manpower Commission, which was terminated on that date, to the Federal Security Agency. This transfer in no way affected the purposes or functions of Procurement and Assignment Service, which from V-J Day on consisted entirely of securing releases of medical officers from the Armed Services to meet acute civilian needs, and in assisting in the 9-9-9 program for deferment of medical officers on inactive duty serving as interns and residents and the reconversion of that program to peacetime basis as previously mentioned.

After February 15, 1946, the Appeals Committee of the Directing Board of Procurement and Assignment Service stopped considering appeals for the release of medical officers from the various branches of the Service, on the ground that a sufficient number of medical officers had returned to overcome all serious shortages of medical care. Despite that fact, appeals have continued to be made through the Central Office, in exceptional cases, and with the assistance of the Assistant Executive Officer of Procurement and Assignment in Washington, who has been in charge for some time, releases have been secured in some instances.

Since the reconversion of the 9-9-9 intern-resident program was completed on April 1, and since no further formal appeals would be considered by the Appeals Committee of the Directing Board after February 15, 1946, the Procurement and Assignment Office for Physicians for Texas was officially closed on April 1, 1946.

Prior to its closure, in accordance with prescribed procedure, official request was made by the Secretary of the State Medical Association of Texas that all the files and records of the office become the property of the Association. We are informed that this request will be granted, and thus these files and records will become the property of the State Medical Association of Texas, to be disposed of as directed by its Board of Trustees. The physical property of the offices, such as filing cabinets,

[1]Texas Hospital and Intern Resident Staffs (Ed.), Texas State J. Med. 61:392 (December) 1945.

desks, typewriters, and so forth, will, of course, be taken over again by the proper governmental agency.

We cannot close this report without again expressing our deepest appreciation of the fine coöperative services rendered by the 126 local Procurement and Assignment Advisory Committees throughout the State. Without their services Procurement and Assignment Service could not have functioned effectively. We also wish to thank Dr. S. E. Thompson of Kerrville, Chairman of Procurement and Assignment Service for the Eighth Service Command, for his always ready, sound advice and counsel when called upon.

We feel that the medical profession of Texas and the Nation, can look back with reasonable pride on the job it did voluntarily in World War II, in determining which doctors should serve in the Armed Forces and which should stay at home and take care of the civilian population in private practice, industry, and public health. Despite readily admitted mistakes and weaknesses in the program, we believe that Procurement and Assignment Service, operated voluntarily and without compensation, by the free, unregimented medical profession of this country, did a better job than could possibly have been done by any paid agency of the Federal Government.

Respectfully submitted,

HOLMAN TAYLOR, Chairman,
R. B. ANDERSON, Vice Chairman,
G. F. THORNHILL,
E. F. CADENHEAD,
C. G. SWIFT,
J. S. MCCELVEY.

President Connally: The report will be referred to the Reference Committee on Medical Service and Public Relations.

Next will be the report of the Committee on Maternal and Child Health.

Dr. Holman Taylor, the Secretary, then presented the report of the Committee on Maternal and Child Health, as follows:

REPORT OF COMMITTEE ON MATERNAL AND CHILD HEALTH

For the year 1944:

1. The Committee received, reviewed, and approved, the comprehensive study and program of the Department of Pediatrics, Department of Maternal and Child Welfare, of the Texas State Board of Health, and the program is being put into effect.

2. The Committee, with Dr. H. Leslie Moore as acting chairman, attended a meeting called by the State Board of Health to study and to put into effect preventive and control procedures to combat the recent epidemic of infantile paralysis. The minutes of that meeting are on file with the Secretary of the State Medical Association of Texas.

For the year 1945:

A meeting of the Committee, in conjunction with the Texas Interprofessional Commission on Child Development, D. B. Harmon, Chairman, was held at Fort Worth, November 27. The procedure of the Committee was as follows:

1. Renews request for compulsory blood Wassermanns by recognized medical laboratories, a requisite to obtaining marriage license.

2. Again requests removal of the necessity for the physician to determine "legitimacy" of child and so state in answer to question No. 6 of the birth certificate.

3. In compliance with the request of the Texas State Interprofessional Commission on Child Development, and in order to have a permanent member of the commission, the State Medical Association and the Committee on Maternal and Child Welfare suggest a revision of the By-Laws of the State Medical Association so that the committee may be as follows:

a. The Committee shall consist of five members.

b. One member shall be selected from the Texas Association of Obstetrics and Gynecology and one from the State Association of Pediatricians.

c. The period of service shall be one, two, and three years.

d. The chairman of the committee shall be appointed by the President of the State Medical Association of Texas from the members carried over from the previous year.

e. The Chairman on Maternal Health and Child Welfare is automatically a member of the Texas Interprofessional Commission on Child Development.

The Committee approved and voted unanimously to coöperate with the Division on Maternal and Child Welfare on the following six points, as outlined by Dr. Carl F. Moore, Director of Division of Maternal Health and Child Welfare, State Department of Health:

1. We would like to maintain the prenatal conferences over the state, and to institute new ones when the physicians, nurses, and other personnel are available.

2. We wish to do the same with well-child conferences.

3. We plan to continue the coöperation of the medical aspects of the school health program with the Division of School Health Services under Dr. Harmon.

4. We plan to repeat in November the graduate course of one week in Pediatrics at the University of Texas Medical School in Galveston, as was done in May.

5. We would like to present courses in coöperation with the medical schools in the state, in Obstetrics, which courses would be maintained under the general principles as the course in Pediatrics was done. That is, the practicing physicians would receive transportation and a stipend of $8.00 for each day they are in attendance on the course. The course is to be given by the Obstetrical Service of the Medical School. The State Department of Health would pay for the stipend and travel for two out-of-state speakers, and the Medical School pay for as many out-of-state speakers as they desire. The course would consist of a week's intensive lecture and clinical work aimed at the obstetrical difficulties that cause the highest maternal mortality in the State.

6. It is contemplated, though it is doubted that it can be done this year, to set up a graduate course of such nature for Negro physicians.

Respectfully submitted for the Committee on Maternal and Child Health,

ROY L. GROGAN, Chairman.

President Connally: This report will be referred to the Reference Committee on Scientific Work.

Report of Committee on Tuberculosis.

Dr. Holman Taylor, the Secretary, then presented the report of the Committee on Tuberculosis, as follows:

REPORT OF COMMITTEE ON TUBERCULOSIS

The Chairman of the Committee on Tuberculosis, Dr. R. G. McCorkle, and Dr. Harvey Renger, attended a meeting of the Texas Tuberculosis Association held in Austin, September, 1944. This was a one day session at which scientific papers were presented. The program was excellent and the attendance was very good.

The Chairman of the committee has attended all the meetings of the Executive Committee and the Board of Directors of the Texas Tuberculosis As-

sociation which have been held in Austin for the last year, also two meetings of the State Board for Vocational Education, one held in Houston and one in Waco, as a member of the Medical Advisory Committee on Tuberculosis.

There is much work to be done in the tuberculosis field in Texas. I believe that our Committee on Tuberculosis should work with the Texas Tuberculosis Association as much as possible. Your Chairman has also attended all of the meetings of the Regional Tuberculosis Council for Bexar County. He is glad to have served as the Chairman of the committee, and will be pleased to help in any way that he can.

This Committee is convinced that it could do better work through the years, if its membership were on a long-time, overlapping term-of-office basis. Thus the committee would be able to set up a continuing policy. It is recommended that the By-Laws be changed accordingly.

We approve the following program of Statewide Tuberculosis Control, recently adopted by the Board of Directors of the Texas Tuberculosis Association:

1. Promote adequate hospitalization for tuberculosis patients in Texas through the establishment, by the State, of district tuberculosis sanatoria.

Cognizant of the intention of the State Board of Control to use Fort Ringgold, located on the Texas-Mexico border, in Starr County, as a tuberculosis sanatorium, the Association recommends that funds be appropriated by the next legislature to establish a sanatorium in East Texas, with provision for Negro patients, and that the present Negro sanatorium at Kerrville be converted into a sanatorium for white patients. In the event that hospital beds are not available for tuberculosis patients in Southwest Texas through the use of Fort Ringgold or other facilities in that area, it is recommended that the establishment of a sanatorium in the southwest section of the state be given priority over the establishment of a sanatorium in East Texas since the tuberculosis problem in Southwest Texas is greater than in any other area.

Following the establishment of sanatoria in the two sections of the State above named, the Association recommends the establishment of a sanatorium in Central Texas and a sanatorium in the extreme western portion of the State.

2. Recognizing the need for expanding facilities of local tuberculosis clinics now in operation and for establishing additional clinics in other strategic localities, the Association recommends that adequate funds, especially earmarked for the establishment and operation of local tuberculosis clinics, be requested by the State Health Department of the State Budget Committee. It is recommended that policies for operating the clinics be determined by the Tuberculosis Committee of the State Medical Association of Texas.

3. Facilities for major chest surgery in the two State sanatoria now in existence have long been advocated by the Directors of the Association, who recommend early provision, by the State, of facilities and personnel to render this service.

4. For adequate follow-up on tuberculosis cases, additional public health nurses are urgently needed. The Association recommends that the State Health Department request the State Budget Committee to include in the appropriation for the Tuberculosis Division of the State Health Department a minimum of $25,000 a year for this service.

5. The Association recommends the appointment of the Tuberculosis Committee of the State Medical Association of Texas as an advisory group on management and operation of State sanatoria, and on medical policies of hospitalization of tuberculosis cases, the services of this committee to be offered to the Board of Control in its future sanatorium program.

6. The Board of Directors has approved plans for a statewide educational campaign to be conducted by the Association, designed specifically to inform the citizens of Texas of the tuberculosis hospital, clinic, and nursing needs of the State.

The long-range objectives of the Association are:

1. *Modern Tuberculosis Laws.*—Realizing that many Texas laws relating to tuberculosis are inadequate, the Association recommends study and revision, where necessary, of the present laws, in order that the most effective use possible may be made of the expanded facilities anticipated for tuberculosis control in the State.

2. *Financial Aid to the Bread-Winner.*—When the bread-winner of a family is the victim of tuberculosis, and his economic condition is such that his dependents would be without financial resources during the period necessary for his medical treatment and hospitalization, financial aid should be provided. Recommendations in this connection will be based on further study of the problem.

3. *Expansion of Diagnostic Services.*—Some expansion of diagnostic services is under way at present by both official and voluntary health agencies. When treatment facilities are such that the present load of tuberculosis cases can be handled effectively, the Association recommends further expansion of diagnostic services.

4. *Rehabilitation.*—When the expansion of hospital and case-finding facilities increases the need for expansion of rehabilitation services to the tuberculous, the Association recommends such expansion.

5. *Statewide Educational Service.*—The Association will provide, on a statewide plan, more extensive education of the public relative to the prevention and control of tuberculosis.

The Association is soliciting endorsement of this program, and coöperation in its development, by all agencies and individuals interested in tuberculosis control in Texas. To that end, copies of these recommendations are being disseminated and criticisms or further suggestions invited.

Respectfully submitted,

R. G. McCorkle, Chairman,
R. B. Homan, Jr.,
C. B. Thayer,
Harvey Renger,
J. S. Wootters.

President Connally: The report will be referred to the Reference Committee on Scientific Work.

Next is the report of the Committee on Venereal Diseases.

Dr. Thomas M. Jarmon, of Tyler, Chairman, then presented the report of the Committee on Venereal Diseases, as follows:

REPORT OF COMMITTEE ON VENEREAL DISEASES

Noteworthy progress has been made in the treatment of venereal diseases and, therefore, the varied problems for their control since the last annual session of the State Medical Association. Accumulated clinical experience and data have made it possible to make a fair evaluation of the indications and limitation of new chemotherapeutic agents in the field of venereal diseases.

With any reasonable program for the education of the public, and a rigid adherence on the part of physicians and public health agencies to accepted regimen, penicillin, a specific for gonorrhea, appears to be the

agent for final accomplishment of our efforts of control of this disease.

Penicillin, although a valuable adjunct to our already fairly satisfactory armamentarium in the treatment of syphilis, must await further research and accumulated clinical experience before anyone can say that it will be effective in any given case; therefore, a word of caution would seem timely in its overzealous use and promises for the moment. Our Committee has used such caution the only occasion it has been called upon to advise—this in the instance of public health agents proposing to cure, or at least that would have been the assumption of the layman, syphilis by intensive medication in the span of a few days.

Respectfully,

THOMAS M. JARMON, Chairman,
A. A. TERRY,
W. F. HASSKARL,
R. K. HARLAN,
A. G. BARSH.

President Connally: The report will be referred to the Reference Committee on Scientific Work.

Next is the report of the Committee on Industrial Health.

Dr. M. M. Brown then presented the report of the Committee on Industrial Health, as follows:

REPORT OF COMMITTEE ON INDUSTRIAL HEALTH

This report of necessity covers a period of two years. No attempt will be made to compile any statistics, mainly because the war work of the committee has about come to an end, and its peacetime efforts have not yet been taken up. It will be recalled that this committee has devoted its time and attention mainly to the matter of supplying war and other industries with medical service made necessary by the war, a function, really, of the State Committee on Procurement and Assignment of Physicians. The Committee on Industrial Health was asked to take care of this part of the problem of the Committee on Procurement and Assignment, because of its familiarity with the industrial situation throughout the state, and a knowledge of its needs by way of medical service.

The plan of Procurement and Assignment of Physicians contemplated that the medical population be divided into four brackets, namely, those who served the Armed Forces; those who served War Industry; those who served the Public Health, and those who served the Public. It has been our task to help the Procurement and Assignment Committee care for the second category. In this capacity, we have helped in many cases, and made many replacements.

This service has been progressively reduced as the end of the war conditions has approached. Our Committee has helped, and will continue to help, in this respect until the situation no longer needs our attention. It should then be the purpose of the Committee to devote its time and attention to the health hazards of industry, and improvement in that respect throughout industry in the State of Texas.

Respectfully submitted,

JACK FURMAN, Chairman,
CARL MCCURDY,
RICHARD KEYS,
J. W. SIMONS,
M. M. BROWN.

President Connally: The report of the Committee is referred to the Reference Committee on Medical Service and Public Relations.

Next is the report of the Committee on Malaria.

Dr. Holman Taylor, the Secretary, then presented the report of the Committee on Malaria, as follows:

REPORT OF THE COMMITTEE ON MALARIA

The subject of malaria is one of rapidly increasing importance in Texas with the return of our soldiers and sailors from the South Pacific and from Africa.

Steps should be taken immediately to apprise the medical profession of the possible magnitude that the problem is assuming in the post-war period.

An exhibit should be put on at the state meeting in Galveston by the Texas State Department of Health in coöperation with the Department of Preventive Medicine and Public Health of the University of Texas Medical School.

Dr. Wendell Gingrich (Ph. D.) should be invited to participate in the exhibit, to bring to the attention of the profession the new antimalaria drugs, and he should be invited to present a paper before the Section on Public Health of the Society, at the next meeting, on the new quinoline preparations used in the prevention and suppression of malaria.

Respectfully submitted,

GEORGE R. HERRMANN, Chairman.

President Connally: The report is referred to the Reference Committee on Scientific Work.

Next is the report of the Committee on Library Endowment.

Dr. B. E. Pickett, Sr., Chairman, then presented the report of the Committee on Library Endowment, as follows:

REPORT OF COMMITTEE ON LIBRARY ENDOWMENT

Your committee on Library Endowment has found it difficult, as we are sure have the other committees of the Association, to develop a program for the year's work because of our inability to get together on account of the war. Planning by mail, with all members extremely busy in practice, is slow and unsatisfactory but was the best that we could do.

After a review of present resources of the Library, both with regard to finances, equipment and material content, such as books, periodicals, reprints, motion picture films, and museum articles, we gave consideration to plans heretofore made and policies being carried out by the Trustees in the development of the Library. In this study we were aided by information furnished by Dr. R. B. Anderson of the Central Office, who is officially the Librarian of the Texas Memorial Medical Library Association. For the benefit of members of this House who may not have the information, we call attention to the fact that several years ago the Trustees of the State Medical Association, realizing that it would not be possible to develop a great medical library from annual membership dues alone, to serve all doctors in Texas, and eventually to furnish literature on medical subjects to Texas laymen, created the Texas Memorial Medical Library Association in order that endowment funds might be secured. This organization was so arranged that its membership is limited to the five Trustees of the State Medical Association; thus, expenditure of any funds secured by this Association are safely kept within the control and direction of the Trustees of the State Medical Association who, in turn, are guided by the policies set up by this House of Delegates. Donations made to the Texas Memorial Medical Library Association as endowments, or otherwise, are deductible from income taxes. They would not be so deductible if made to the State Medical Association, the activities of which are not solely scientific, as are those of the Texas Memorial Medical Library Association.

Since the perfection of the organization referred to, eleven endowment funds of $1,000 each have been established, a complete account of which funds is given annually in the report of the Board of Trustees to this House of Delegates.

Your committee gave special consideration to the needs of the Library at present, to which we refer briefly:

(1) Immediately that the war emergency is over and building materials become available, a modern fire-proof building should be erected. The contents of our Library now are highly valuable and no amount of insurance could replace them if they were destroyed by fire.

(2) The number of journals received by the Library might well be doubled or even tripled. Let us not forget that these journals are readily available for loan to any reputable doctor in Texas.

(3) The Library needs to purchase a great many books it cannot buy with its present operational funds.

(4) Microfilm and photostatic services need to be developed in the Library, and would add greatly to its services to members of the Association.

(5) The Library should collect and catalogue pathological slides for lending to members. This would be an especially valuable service.

(6) When it is possible to add the services which these suggestions, if carried out, would make available, there would be need for an increased staff to translate articles or abstract articles in foreign journals as needed or desired. This would be an outstanding service.

In order to place these needs before members of the Association to interest them in a program of properly endowing the Library of the State Medical Association, your committee addressed a letter outlining these needs, over the signature of members of the committee, to the presidents and secretaries of county medical societies in Texas. This letter was mailed to secretaries of county societies under date of January 4, 1945. Because of the change in officers of county medical societies at the beginning of the new year, letters to presidents were held up until the names of new presidents could be ascertained. Additional letters were sent to the presidents, secretaries, and members of county medical societies in March, 1946.

Not to prolong this report, we advise that in response to all these letters, donations to a "County Medical Society Library Building Fund," for the Library of the State Medical Association of Texas, have been received from county medical societies as follows:

Austin-Waller Counties Medical Society		$ 5.00
Bexar County Medical Society		
Dr. Alfred Breuer, San Antonio	$ 5.00	
Dr. E. V. DePew, San Antonio	25.00	
Dr. Yone Soma, San Antonio	50.00	
Dr. I. C. Skinner, San Antonio	25.00	
Dr. Walter G. Stuck, San Antonio	100.00	
		205.00
Bowie County Medical Society		25.00
Brazos-Robertson Counties Medical Society		
Dr. J. E. Marsh, College Station		5.00
Cameron-Willacy Counties Medical Society	25.00	
Dr. Henrich and Annie T. Lamm, La Feria	10.00	
Dr. T. O. Andrews, Brownsville	3.00	
		38.00
Dallas County Medical Society		
Dr. M. F. Waldman, Dallas	5.00	
Drs. Paul C. Williams and T. W. Bywaters, Dallas	25.00	
Dr. G. D. Mahon, Dallas	50.00	
Dr. H. S. Aronson, Dallas	10.00	
J. A. Majors Company, Dallas	500.00	
		590.00
DeWitt County Medical Society		15.00
Ector-Midland-Martin-Howard-Andrews-Glasscock Counties Medical Society		
Dr. J. K. Wood,, Odessa		25.00
Galveston County Medical Society		
Dr. G. W. N. Eggers, Galveston		25.00
Harris County Medical Society		
Dr. Herman L. Gardner, Houston	10.00	
Dr. H. Caplovitz, Houston	5.00	
		15.00
Hidalgo-Starr Counties Medical Society		
Dr. Charles Mims, Mission		10.00
Jasper-Newton Counties Medical Society		40.00
Jefferson County Medical Society	100.00	
Dr. H. B. Eisenstadt, Port Arthur	5.00	
		105.00
La Salle-Frio-Dimmit Counties Medical Society		
Dr. B. E. Pickett, Carrizo Springs		25.00
Medina-Uvalde-Maverick-Val Verde-Edwards-Real-McKinney-Terrell-Zavala Counties Medical Society		
Dr. Raul M. Montemayor, Eagle Pass	5.00	
Drs. R. N. Graham, and B. L. Burditt, Del Rio	10.00	
Dr. J. D. Williamson, Castroville	5.00	
Crystal Hospital, by Dr. Cary Poindexter	5.00	
Dr. Orin McMillan, Eagle Pass	5.00	
		30.00
McLennan County Medical Society		
Dr. John Thompson, McGregor	10.00	
Dr. I. Warner Jenkins, Waco	5.00	
		15.00
Navarro County Medical Society		
Dr. L. E. Kelton, Jr., Corsicana		10.00
Potter County Medical Society	50.00	
Dr. J. B. White, Amarillo	25.00	
		75.00
Tarrant County Medical Society		
Dr. Harold J. Shelly, Fort Worth	10.00	
Dr. John J. Andujar, Fort Worth	30.00	
Dr. R. B. Anderson, Fort Worth	10.00	
		50.00
Tom Green-Coke-Crockett-Concho-Irion-Sterling Sutton-Schleicher Counties Medical Society		
Dr. R. L. Powers, San Angelo		15.00
Travis County Medical Society		50.00
Upshur County Medical Society		
Ragland Clinic-Hospital, Gilmer	10.00	
Drs. H. J. Childress and T. E. Marshall	10.00	
		20.00
Walker-Madison-Trinity Counties Medical Society		50.00
Wharton-Jackson-Matagorda-Fort Bend Counties Medical Society	50.00	
Drs. Frank R. Rugeley and F. J. L. Blasingame, Wharton	25.00	
		75.00
Wichita County Medical Society		25.00
TOTAL		$1,543.00

We are pleased to report that the JOURNAL has supported the work of our committee by publishing editorial discussions of its efforts to secure endowment funds for the Library, in the February, March, April, May, June, July, and September, 1945, and April, 1946, issues.

Your committee is of the opinion that the Library is one of the most important activities of the Association. Its potentialities in service to the membership are almost unlimited. While it has rendered outstanding service to members with comparatively limited operational funds, we believe that its importance and its usefulness has not received anything like the consideration it deserves. In this connection, we think that the Committee on Library Endowment, which is now a special committee of the Association, appointed at will by each incoming president, should be, instead, a permanent, standing committee of the Association. Further, in order for the com-

mittee to have a continuing policy and definite objectives which cannot be accomplished in one year, we believe its personnel should be on an overlapping term of office basis, as are other important councils and committees of the Association.

Therefore, your committee wishes to offer the following amendment to the By-Laws of the State Medical Association, and moves its adoption:

Amend Chapter 9, of the By-Laws, January, 1945, edition, by inserting the following matter between Sections 9 and 10 (page 22), renumbering all following sections accordingly:

"Section 10. (a-7). The committee on Library Endowment shall consist of five members. The members of the first committee shall be appointed for one, two, three, four and five years, respectively, and thereafter the President-Elect shall appoint to fill vacancies created by expiration of term of office. These appointments shall be confirmed by the House of Delegates and shall be considered at the time of election of officers. The chairmanship of the committee shall be determined each year by the President-Elect when he assumes the office of President. It shall be the duty of this committee to secure donations and endowment funds for the Texas Memorial Medical Library Association, and to keep the membership of the Association acquainted with the services offered by the Library to members and the public, and its needs for continuous greater development and greater services. This committee shall present to each annual meeting of the House of Delegates a report covering its activities during the preceding year."

In closing this report, your committee expresses regret that it has been unable to secure larger and more donations to the endowment fund of the Library, but it believes that if the by-law recommended in this report is adopted, greater success will be obtained by subsequent Library Endowment Committees in the future.

Respectfully submitted,

B. E. Pickett, Sr., Chairman,
A. L. Ridings,
Orville E. Egbert,
V. R. Hurst,
L. C. Powell.

President Connally: This report will be referred to the Reference Committee on Finance, except that part pertaining to Amendment to the By-Laws, which will be referred to the Reference Committee on Amendments to the Constitution and By-Laws.

Dr. Holman Taylor, the Secretary, then presented the report of the Liaison Committee, Lone Star State Medical, Dental and Pharmaceutical Association, as follows:

REPORT OF LIAISON COMMITTEE, LONE STAR STATE MEDICAL, DENTAL AND PHARMACEUTICAL ASSOCIATION

The last report made by this committee and published, was that of 1944. There has been no activity of our group during the past year. The unsettled state of affairs in general and in particular has prevented that. The usual Clinic for Negro Physicians was held at Prairie View Normal this year, and our committee had planned to be represented there, but, for one reason or another, no member of the committee could be present except Chairman Dr. Connally, who briefly addressed the assembled Negroes at the Clinic. There was no opportunity for the committee to function under those conditions.

The State Medical Association has undoubtedly continued to render such service to the Negro physicians of Texas as it has been in a position to render, and our committee feels that this attitude will be maintained. Just how our organization can best help Negro physicians must be determined by conferences with their representatives, and we are very hopeful that such conferences will be held during the next year.

Whether or not we have accomplished very much along the lines of our duties and obligations, the fact remains that there has been no change in the mutual interests of our two racial groups in the medical field. We remain a co-sponsor for the Postgraduate Medical Assembly for Negro Physicians, held at Prairie View Normal each year. We have heretofore endorsed the suggestion that a Medical College be set up at Prairie View and Houston, depending upon whether or not it is to the best interest of the Negro medical student that such be done. The decision recently made to convert Prairie View College into a University of the first class for our Negro citizens might be a predicate for something of the sort. If so, our committee recommends that our Association do everything possible to further the interests of such an institution.

Respectfully submitted,

H. F. Connally, Chairman,
Holman Taylor,
S. E. Thompson,
C. E. Scull,
H. E. Griffin.

President Connally: This report will be referred to the Reference Committee on Reports of Officers and Committees.

President Connally: Next is the Presentation of Fraternal Delegates.

Secretary Taylor: There is, so far as I know, just one Fraternal Delegate who has come to us this year.

The Texas Hospital Association has been thoughtful enough to send a delegate to us to discuss some of the problems in which we are mutually interested. At the instance of the President, I am presenting Mr. William O. Bohman, Superintendent of John Sealy Hospital, Galveston.

Report from Fraternal Delegate of Texas Hospital Association

Mr. William O. Bohman: At a meeting of the Board of Trustees of the Texas Hospital Association, April 26, a reciprocal plan for the establishment of a delegate relationship between the State Medical Association of Texas and the Texas Hospital Association, was approved, and I understand will be presented to the official body of the Medical Association for action during this annual meeting.

It was our pleasure to have with us during the recent annual meeting of our association, in Fort Worth, your assistant secretary, Dr. R. B. Anderson, who spoke on the activities of the Association, particularly as they relate to your expanded public relations program.

On this occasion I am representing the president of the Texas Hospital Association, Mr. Tol Terrell, administrator of the Harris Memorial Methodist Hospital, Fort Worth, and our Board of Trustees in reporting to you major activities in which we believe you will feel an interest.

PERMANENT HEADQUARTERS OFFICE AND EXPANSION OF ACTIVITIES

For the first time since the organization of the Hospital Association in 1930, there was established in Dallas, in February, 1945, a headquarters office. Madelyne Sturdavant, who had served as executive secretary since 1939, while carrying on her work as assistant administrator of the Methodist Hospital in Dallas, became the full time executive secretary and editor.

Outstanding in the expansion of association activities has been the publication of a monthly journal,

which is sent to the officials of your Association, to members of the State Department of Health, and the Advisory Council appointed to advise with the Health Board in the state survey, to be discussed later in the report.

The journal is sent to each of the 565 hospitals in the state, to various department heads, members of allied associations, and to national leaders in the hospital field. The journal, which is the first state hospital association journal of any size, has received national acclaim.

Already many values anticipated from the journal are beginning to be realized. The attendance at the annual convention sessions in March far exceeded any previous record. Hospitals and hospital administrators who formerly had isolated themselves from the general field have begun showing interest in problems of a general nature, as well as in the improvement of their own institutions. Projects which have been undertaken during the year have received a more enthusiastic response; various technical workers are showing an awakened interest in their work and in its relation to the hospital as a whole.

The executive secretary is leaving the work on July 1, to become associated with James A. Hamilton and Associates, hospital consultants. Her successor will be Mrs. Ruth Barnhart, now on the editorial staff of a national dental journal in Evanston, Ill., who has formerly been connected with hospitals and with the editorial staff of a state medical journal. The office staff of the association is being increased to handle the rapidly mounting volume of work.

ORGANIZATION

Membership in the hospital association is limited to hospitals registered by the American Medical Association. The affairs of the association are managed in the interim of annual meetings by a Board of Trustees composed of the President, the President-Elect, the immediate retiring President, the treasurer, and six trustees, two being elected each year for three-year terms. Projects carried on by the Association are developed by councils composed of six members each, the names of which are indicative of their scope of activities: Councils on Administrative Practice, Association Development, Construction and Plant Operation, Government Relations, Hospital Service Plans, Professional Service, and Public Education. Two members to each council are elected each year, for three-year terms. The chairmen of these seven councils comprise a committee on Coördination of Activities, which committee considers projects under development by each council, defines the various programs, and recommends activities to the Board. This group has as its responsibility, also, the development of the annual convention programs.

Touching only a few of the projects under way at this time through the various councils, I should like to give you some idea of activities in which the association interests itself:

Study of present trends in purchasing.

Encouragement of adoption of the American Hospital Association manual on hospital accounting, which will bring about a means whereby hospitals and hospital governing boards may intelligently compare the financial operation of the institution with other institutions of similar size, control, and organization.

Increase of membership, and adoption of a more attractive membership certificate, which would be displayed prominently in the admitting offices of member hospitals.

Study of program of planned maintenance for hospital technical and capital equipment.

Study of existing public relations programs in Texas hospitals.

Consideration of a suggested public relations program, offering timely material for the programs of hospital women's auxiliary meetings and for public consumption.

Major projects of special interest will be reviewed briefly:

EDUCATIONAL INSTITUTES

Under the joint sponsorship of the American Hospital Association and the Texas Hospital Association, an educational program of institutes in various phases of hospital activity are being developed. Last year, in Houston, a week's institute on personnel was conducted with an enrollment of sixty-five. There will be an institute for hospital accountants at the Houston University in Houston, in June, and in December an institute for medical record librarians is being planned at the Dallas College branch of Southern Methodist University in Dallas.

RECOMMENDATIONS TO HOSPITALS FOR THE ESTABLISHING OF MORE ADEQUATE NURSING PERSONNEL POLICIES AND SALARIES

In line with State Association activities throughout the nation, a committee of the Texas Graduate Nurses Association and a committee of the Texas Hospital Association have developed recommendations on nursing personnel policies, practices, and salaries to serve as a guide to hospitals in improving working conditions, to bring about stabilization of nursing personnel and increased efficiency in nursing service. These recommendations were approved and adopted by the graduate nurses association, and by the board of the hospital association. They will appear in the journal of the hospital association within the very near future.

Hospitals are recognizing their tardiness in giving proper consideration to personnel policies, and much emphasis is now being placed on this subject in the state association as in the national association. One of the most recent projects from a national level has been the recently published report by the American Hospital Association on survey of hospital personnel salaries, hours, and maintenance.

LICENSING LAW FOR NURSE AIDES

The wide and satisfactory use of the aide to supplement the work of the graduate nurse has brought to prominence throughout the nation the question of licensing of this group of subsidiary workers. That there is a place for such a group seems unquestioned. The advisability of a licensing law as a means of control and as a protection to the public; the establishment of qualifications for licensure; the manner, place, and type of training; and what she shall be called, are questions which are receiving consideration at this time by committees of the Texas Graduate Nurses Association and the Texas Hospital Association.

CARE OF VETERANS IN CIVILIAN HOSPITALS

The Hospital Association has made numerous contacts with the Veterans Administration, expressing eagerness to consider and recommend to hospitals a plan facilitating the care of veterans in civilian hospitals. This work is moving slowly in Texas due to some reorganization of the Veterans Administration offices, but the Association has been assured that a proposal will be submitted at the earliest possible date. Plans are in existence in several states now.

BLUE CROSS PROGRAM

The Blue Cross program in Texas has not enjoyed its proportionate share of the increase in enrollment to the present national enrollment of twenty-one million. Numerous reasons are apparent: the size of the state, the existence of an unusually large number of hospitalization plans, the lack of a medical and surgical protection—and equally as significant or perhaps more significant, the lack of an enthusiastic

backing by the medical profession or the medical association officially.

One of these handicaps has been removed in the organization of the Blue Shield, companion medical and surgical service. Blue Cross has grown to an enrollment of 148,000, and the infant medical and surgical service which is being offered, now in its first year, without concentrated promotional efforts has reached 15,000. You are aware and hospitals are aware of the fact that this record, while commendable, might by now have been greater, with a coördinated and united push by doctors as well as by hospitals.

HOSPITAL CONSTRUCTION BILL—S. 191

On the strength of passage of the Hospital Construction Bill, S. 191, now pending in our Congress, with which you are all familiar, state studies of hospital and health facilities are now in some stage of development in every state in the union. Survey material was prepared at a national level, and offered to states to make possible a correlation of data which would result in a comprehensive picture of the present facilities and need for further construction. This work was initiated by the Commission on Hospital Care in Chicago, which is a non-government public service group financed by contributions from three national foundations, and which represents the National Hospital, Medical, Nursing, Health, and Welfare Associations.

The survey in Texas is being conducted under the direction of the State Board of Health, whose responsibility is delegated to the State Health Officer, Dr. George W. Cox. An advisory group to assist in this project was appointed by the governor, composed of Texas hospital administrators, and enlarged to include representatives of the State Medical Association. Similar bodies in other states have found public relations and public educational value in the expansion of their advisory groups to include a wider range of health, welfare, and public interests.

Mr. N. B. Roberts, recently discharged from the Medical Administrative Corps of the Army and a former hospital administrator, is in charge of the survey in Texas, which is progressing at a fairly satisfactory rate. This is a tremendous undertaking which will result in an analysis of hospital facilities never before available.

Merits and demerits of the hospital construction act have been discussed. As an association, it is our position that the advantages of the program far outweigh any objections proposed. Certainly the more equitable distribution of hospital facilities as a result of this program will bring about a more even distribution of medical care by voluntary effort.

The potentialities of future hospital planning based on a comprehensive survey of existing facilities and needs within a community are being realized to some degree already by communities which have undertaken such a study before completing plans for extensive expansion of existing facilities. Cognizance is being given in such coördinated planning to the need for adjusting hospital facilities to the scientific advances in recent years, such as the feasibility of caring for tuberculous and psychiatric cases in units within a general hospital, the rapid advance of preventive medicine, the need for proper facilities for chronic, convalescing, and geriatric cases, and so forth.

REQUEST FROM OSTEOPATHIC ASSOCIATION FOR MEETING WITH REPRESENTATIVES OF THE TEXAS HOSPITAL ASSOCIATION

The Texas Association of Osteopathic Physicians and Surgeons has renewed a request initiated by them last year, for a meeting of a committee of their association with a committee of the Texas Hospital Association. The agenda submitted by the Osteopathic Association for consideration at such a meeting is:

1. Attitude of hospital association as to the educational qualifications of doctors practicing in hospitals.
2. Ethical relationship.
3. Legislation.
   a. Prospective laws defining and affecting hospitals.
   b. Federal grants in aid affecting hospitals and participation in same.
   c. The objections of the hospital to the Hospital Bill 314, as introduced in the last legislature.
4. Attitude of Texas Hospital Association toward osteopathic hospital participation in hospital and medical service plans.

The Board of Trustees of the Texas Hospital Association has authorized the president to appoint a committee to meet as requested, provided a similar committee is present from the State Medical Association of Texas.

That legislation similar to House Bill 314, and many other measures affecting hospitals and doctors, will be before us in the next Legislature is recognized. The hospital association is keenly aware, too, of the need for coördination of thinking and planning by the two associations on these and other problems affecting the medical, hospital, and health fields.

The opportunities for joint consideration of these and similar problems which have been enjoyed by the two associations only recently should mean a great deal to the associations in the effectiveness of their respective programs.

Such joint consideration of problems in the state of Michigan has developed to the point of organization of a Michigan Health Council, comprised of representatives of the State Medical Association, State Hospital Association, and Blue Cross Plan. The work and study of this group has received national attention, and its purposes, its plans, and its effectiveness up to this time seem worthy of consideration by other states.

Thank you. (Applause.)

President Connally: This report will be referred to the Reference Committee on Medical Service and Public Relations.

Secretary Taylor: I owe somebody an apology, starting with our President. I said there were no other Fraternal Delegates. I now have credentials from the New Mexico Medical Association accrediting Dr. C. A. Miller, of Las Cruces, N. M., as a Fraternal Delegate.

Dr. Miller.

ADDRESS OF DELEGATE FROM NEW MEXICO MEDICAL ASSOCIATION

Dr. C. A. Miller, of Las Cruces, N. M.: Mr. President, and members of the State Medical Association of Texas: I bring you greetings from the New Mexico Medical Society. I am the President-Elect of that society. I am the oldest President they have ever had, being 75 years of age, and I have overcome some difficulties, in that when I started to school, I could not speak a word of English. My parents came from the Old Country.

I have practiced medicine forty-nine years, six in Indiana, four in Illinois and thirty-nine in New Mexico.

When I came to New Mexico it was still wild and wooly out there. There were no automobiles, no roads—just trails. Everybody rode horseback, including myself. Most of the people we met were from Texas. I do not know why.

Texas doctors have been coming to us. We have had Dr. Scott, Dr. Rosser, old Dr. Moore, who would

be a hundred years old if he were still living, and many other Texas doctors with us at our meetings.

I have two brothers practicing medicine in Texas. One came to Texas in 1894. He was in the State Legislature several terms. I guess you have heard enough from me. I am glad to be here. Thank you. (Applause.)

Dr. John T. Moore: Mr. President, I cannot help rising at this point to acknowledge that I am still living. I hope to visit New Mexico again. (Applause.)

Secretary Taylor: I have a communication in which inquiry is made as to whether there is any law of the State Medical Association against Negro doctors joining the Association, and also asking whether there were programs being conducted by Negro doctors in medical societies in this state. I have advised that there is a by-law in our Association which says only white doctors are eligible to membership; that there are medical societies in the state which invite Negro doctors to participate in their meetings from time to time, which is purely a local matter.

On motion of Dr. E. W. Bertner, seconded by Dr. L. B. Jackson, the communication was ordered filed.

Secretary Taylor: I have a letter from Dr. Charles W. Pemberton, of Houston, who is a high class Negro doctor. His father was one of the best Negroes I ever knew, a professor in the Negro schools over in my home town, Marshall. Dr. Pemberton is the kind who wants to get ahead, and wants his race to get ahead, and he wants to help.

He asked particularly about the plan for medical and surgical service, especially the Blue Cross. His group wants to go with us to Washington and appear against these bills. He also wants to take up with the proper officials in the State Medical Association the matter of seeing whether it would be feasible or desirable to have a Negro group visit our exhibit here. It was decided because of the nature of this hotel and the circumstances existing here, that it would be unwise for us, the guests, to ask the hotel to admit into the institution, on more or less of a social basis, members of the Negro race. So we wrote him that we would rather not give the matter consideration at this time.

It was moved by Dr. E. W. Jones, of Wellington, and seconded by Dr. A. R. Shearer, of Mont Belvieu, that the communication be filed. The vote was taken and the motion prevailed.

Secretary Taylor: Mr. President, I have a file here from Dr. McElhenney, of Austin, about the American Academy of Pediatric Study of Child Health Service. There is no need of presenting this communication, except to say that this matter has been under discussion, and the doctor would like to address this body.

President Connally: We are glad to have Dr. McElhenney.

Dr. McElhenney presented the director of the Study of Child Health Service of the American Academy of Pediatrics, Dr. John P. Hubbard, Washington, D. C.

Study of Child Health Service

Dr. Hubbard explained in detail the plan of the study on child health conducted by the American Academy of Pediatrics, in coöperation with the Children's Bureau and the United States Public Health Service. The plan in its fullness has been mimeographed and is available to anybody directly interested and concerned. Dr. Hubbard explained in detail the need of a survey such as is being conducted. He advised that the American Academy of Pediatrics has taken full responsibility for the conduct of the study, which study is being made by doctors and financed by doctors, and with the help of interested groups. The Children's Bureau and the Public Health Service are assisting in the survey by tabulating the results of the research made by the pediatricians and those employed by pediatricians. The work is being directed by Dr. Hubbard. He said that this is probably the first time the federal services coöperating in the matter have ever actually worked for doctors. There will be no exploiting of the results, which results will go directly to the representatives of the American Academy of Pediatrics and the coöperating professional groups.

It is the hope of the American Academy of Pediatrics that a better and more evenly distributed health service for children will be set up in these postwar days as a result of the study being conducted. If an essential preventive, diagnostic, and curative medical service of a high quality can be made available now, the health results will be beyond calculations. There are several bills before Congress designed to place the responsibility for the health and welfare of children in the hands not of the medical profession itself, but of the federal government, even though, after all, physicians must be utilized in rendering many services under any of the bills. It seems desirable that those of us who are practicing medicine, and particularly those who are giving special study to pediatrics, should plan and carry out the service rather than have it done by bureaus, no matter how well intentioned and competent they may be.

A committee of nine has been appointed to assemble facts and develop considered opinions on postwar planning around the child. Three of that committee have been selected from the American Academy of Pediatrics, three from the American Pediatric Society, and three from the Medical Advisory Board of the Children's Bureau. Five of these members are in active, private practice of pediatrics. A central office has been set up in Washington, D. C., with a competent staff, all directly responsible to this committee. There will be a limited field staff, to assist the pediatricians of the several states in organizing and carrying on the survey within their own areas. It will probably take two years to complete the factual study. However, local groups will have access not only to the final report containing a digest of the data submitted for their own areas, but also to the current findings. One of the primary purposes of the study is to stimulate local groups to evaluate the services within their own communities as a basis for local planning.

President Connally: This will be referred to the Reference Committee on Reports of Officers and Committees.

Reading of Memorials and Resolutions.

Dr. L. C. Heare presented a resolution adopted by the Jefferson County Medical Society, with reference to the Wagner-Murray-Dingell Bill, and it was referred to the Reference Committee on Resolutions and Memorials.

Dr. A. C. Scott presented Proposed Amendments to Section 1, Article IV, of the Constitution, and Section 3, Chapter II, of the By-Laws. The Proposed amendments were referred to the Reference Committee on Amendments to the Constitution and By-Laws.

Dr. E. W. Bertner, of Houston, presented Proposed Amendments to Section 1, Chapter III, of the By-Laws; Section 1, Chapter IV, of the By-Laws; Section 1, Chapter V of the By-Laws; Section 5 (a-2), Chapter IX of the By-Laws; Section 6 (a-3), Chapter IX of the By-Laws; Section 7 (a-4), Chapter IX of the By-Laws; Section 8 (a-5), Chapter IX of the By-Laws; Section 8 (a-5), Chapter IX of the By-Laws; Section 9 (a-6), Chapter IX of the By-Laws; Section 10 (a-7), Chapter IX of the By-Laws; Section 10 (a-7, Chapter IX of the By-Laws; Section 11

(a-8), Chapter IX of the By-Laws; Section 12 (a-9) Chapter IX of the By-Laws; Section 3 (a) Chapter IX of the By-Laws; Chapter IX of the By-Laws, by adding new section.

The Proposed Amendments were referred to the Reference Committee on Amendments to the Constitution and By-Laws.

Dr. Robert E. Parrish, of Bexar: I would like to call the attention of the Committee on Amendments to the Constitution and By-Laws to Section 1, Chapter XIV, "Assessments," with the view of determining whether or not it would be feasible to write that chapter in a way that would be a little more understandable. It is a bit confusing.

Secretary Taylor: Dr. Dudgeon is Chairman of the Reference Committee on Amendments to the Constitution and By-Laws.

I may explain that this amendment was adopted at the Dallas meeting of the House of Delegates, setting up the Public Relations Activities. The dues were raised to $20, and it was left in the shape it is in now because nobody knew how much money was going to be needed for the activities of that committee. There are only two items which must be cared for under the constitution. One is $3 for subscription to the JOURNAL and the other is $1 for Medical Defense.

THIRD REPORT OF REFERENCE COMMITTEE ON CREDENTIALS

Dr. E. W. Jones: We have two delegates from the same county, where there should be only one, Drs. Traweek and Hines Clark. Traweek is the regular delegate, and Hines Clark was seated this morning.

On motion of Dr. A. C. Scott, seconded by Dr. W. A. Lee, Dr. A. C. Traweek was seated as the delegate from Hardeman-Cottle-Foard-Motley Counties.

Dr. Jones: There are 117 delegates present.

On motion of Dr. W. D. Jones, seconded by Dr. A. R. Shearer, the 117 members listed by the Reference Committee on Credentials, were seated.

On motion of Dr. J. M. Campbell, seconded by Dr. H. E. Whigham, the House of Delegates adjourned at 5:55 p. m., until 8:00 p. m. Wednesday, May 8, 1946.

TUESDAY, MAY 7, 1946

Minutes of the Opening Exercises and First General Meeting

The State Medical Association of Texas was called to order for the Opening Exercises by Dr. Dick P. Wall, of Galveston, Chairman of the General Arrangements Committee, at 9:00 a. m., in the Ballroom, Hotel Galvez, Galveston.

The Rev. Edmund H. Gibson, of Galveston, Rector of Trinity Episcopal Church, delivered the invocation.

PRESENTATION OF WARTIME PRESIDENTS

Chairman Wall: After the strife and turmoil of the past several years in a war torn world, it is a blessing and privilege to have a part, though humble, in opening the first postwar session of this great organization.

It is quite natural that we have set our faces toward a future of hope, progress, and success, and turned our backs to the dark picture and bitter experiences of the past few years. This is well and as it should be. Nevertheless, it is also fitting that we pause, though briefly, to give public acclaim to those who, as our chief officers, served well albeit, *sans stage, sans applause*. It therefore becomes my pleasure to present these wartime officers. Restriction of time makes it necessary that we eliminate speeches by these charming ladies, as much as we would like to hear from each of them. Verily, I say unto you, it was far easier for the camel to thread the proverbial needle's eye than for me to tell four women: One of you may speak but three of you must remain silent.

The twenty-fifth president of the Woman's Auxiliary, who served in 1942-1943, is Mrs. Peyton R. Denman of Houston. Mrs. Denman served her local auxiliary, Harris County, as president in 1931, and is a life member of the Executive and Advisory Boards of this organization. She has served on the State Executive Board, in various capacities, for the past fifteen years. As first vice-president in 1939, she organized six new county auxiliaries and one district auxiliary. She enjoys the distinction of being an honorary member of two county auxiliaries, Houston-Leon-Anderson and Liberty-Chambers. In addition, Mrs. Denman has always been quite active in a number of cultural and civic organizations and the church of her choice. Mrs. Denman. (Applause.)

We come now to the twenty-sixth president, who served in 1943-1944. This very active and dynamic personage served in many local and State Auxiliary offices, and is now chairman of the State Legislative Committee. During the war she found time to act as chairman of the local surgical dressing room of the American Red Cross; also chairman of the Nurses' Aide. She is still active in the Parent-Teachers Association; is secretary of the Pan American Round Table; judge in the state flower show; member of the Fort Worth and Texas Garden Clubs—just to mention a few side lines, and yet she has found time to eat three meals a day and go to the First Christian Church twice each Sunday. Mrs. A. B. Pumphrey. (Applause.)

Back up in the hill country of Texas there are folks who are folks, and they are somebody in their own right. You have to be mighty careful not to fence them in. And if you think I am going to make the irreparable mistake of introducing this next person as merely the wife of a certain well known doctor—Guess again! So I announce to all and sundry that the twenty-seventh president of the Woman's Auxiliary is Mrs. Sam E. Thompson, herself, and that Dr. Sam is just her little old husband.

Furthermore, if anyone thinks they can introduce any bills in the Legislature adverse to the good of the public weal or counter to the principles of Organized Medicine without meeting up with her immediate and active opposition, they are mistaken. It is interesting to know that this lady during her year of office accomplished the amazing feat of sending out over 14,000 cards and letters, in addition to making several trips to Austin in her fight against certain obnoxious bills. And yet in a letter she states, "Again I say I owe to my State Officers and County Presidents and the entire membership of the Auxiliary the credit for whatever success we may have achieved." Far too modest I would say. Mrs. Sam E. Thompson, Steepside, Kerrville, Texas. (Applause.)

Dr. Judson L. Taylor, deceased, seventy-eighth President of the State Medical Association of Texas, occupied the highest office of our Association in 1942-1943. Dr. Taylor graced that office with the charm and dignity so characteristic of him. In memory of him, I now ask you to bow and remain silent for a brief period.

It is regretted that Dr. Charles S. Venable, seventy-ninth President, is not present at this time. We had hoped to have the pleasure of his presenec on this occasion.

The Galveston County Medical Society wishes to bring you a message through its president, Dr. Frances A. Garbade.

ADDRESS OF WELCOME

I was asked to make the Address of Welcome to this Association, to these distinguished and honored

guests, the returned veterans, and to the wives of the members of the Association.

I have never made an address before, so I thought I should find out what an address is. I find that it is a point over here, a point over there, and a lot of bull in between.

We are very happy to have all of you with us as guests of the Galveston County Medical Society. We want you to have a good time. We want you to attend the scientific sessions, and we want you to act just as though you were at home.

The Council on Scientific Work has prepared for you an excellent scientific program. The local committees have worked in coöperation with your state committees in an effort to make this an outstanding meeting of the Association.

We have had one problem that has been troublesome to all of us, and that is the housing problem. Of course, here in Galveston we, too, have had difficulty putting up people for the last few years. Since this is the first postwar meeting, since it is the first time the members have had an opportunity to get together and exchange thoughts and ideas, we expect a record attendance.

We found out just last night one of the reasons why our attendance will be so large. In the invitations and announcements that we sent out the doctors were advised to leave their wives at home. Of course, many of them came along just to see why we wanted them to stay at home. But we are glad to have them, and all of you.

The facilities of the medical school during your stay here are at you disposal. Members of the senior class will serve as guides to show you through the school.

I extend to you a most cordial welcome on behalf of the Galveston County Medical Society. We hope you attend all the scientific sessions. We hope you enjoy all the entertainment. We want you to have a good time. We are very happy to have you with us. Thank you. (Applause.)

Chairman Wall: We will now have greetings from Mrs. Charles B. Alexander, of San Antonio, President, Woman's Auxiliary to the State Medical Association of Texas.

Greetings from the Woman's Auxiliary to the State Medical Association of Texas

It gives me great pleasure today to bring greetings from the Woman's Auxiliary, and to give an account of stewardship to the State Medical Association. We have remembered at all times the abiding nature of our organization, that we are an aid to the medical profession. We are grateful for the confidence extended to us and for the opportunity to be of service to the doctors of Texas.

From its beginning, twenty-eight years ago, the dual purpose of the Auxiliary has been to foster professional good fellowship and to promote health education. Each year has shown new developments as the Auxiliary has accepted new opportunities to be of service to the Medical Association. No new auxiliary is organized unless the doctors of the county want the auxiliary and will stand behind it; and each county medical society is requested to appoint a counselor or advisory committee for its auxiliary.

We have emerged from the war years with fifty-four of our old county auxiliaries still intact, and in recent months have organized four new county auxiliaries.

We plead now, as always, for each doctor's wife to be an active and informed member of the medical Auxiliary; for each doctor's wife, through her social and club contacts, is a molder of public opinion, and her influence should be used to bring about a better understanding between the lay public and the medical profession. The Auxiliary makes better informed doctors' wives through its program concerning medical questions. The doctor's wife wants to know what is going on in the medical world, and is extremely interested in the problems facing her husband's profession, yet the doctor is usually too tired to discuss them with her. Many county auxiliaries have kept abreast of the times by having monthly reviews of the editorial page of the Texas State Journal of Medicine. In reply to a questionnaire, over six hundred doctors' wives declared they had read the Journal every month this year.

A vital part of the work of the Auxiliary is to promote an interest in health education by its program of keeping fit. Believing that health education starts at home and that the medical profession should practice what it preaches, we have a drive each year to get every member of every doctor's family to have a physical check up. We start with the head of the family, the doctor, since we know that the doctor thinks of everyone's health before his own, and since keeping the doctor well is the best service we can render his public and his family; yet there were less than five hundred wives who were able to persuade their husbands to take that yearly check up. Doctors' wives and children made a much, much better record.

The Auxiliary promotes only those causes that the State Medical Association requests that it promote. Every year for the past fourteen years the American Medical Association has requested every county auxiliary to help acquaint the public with *Hygeia*, the only official health magazine of the American Medical Association. The purpose of *Hygeia* is to educate the public as to what is true and what is false, what is scientific medicine and what is quackery. Since *Hygeia* is the doctors' own magazine it should be in every doctor's office. The Auxiliary has placed *Hygeia* in schools all over the United States, and hundreds are using it as a text in health education classes. Texas auxiliaries sold nearly eight hundred *Hygeia* subscriptions, and gave nearly three hundred subscriptions to schools and libraries in Texas. One of our small auxiliaries, the Childress-Collingsworth-Hall Counties, won a third prize in the National Hygeia Contest.

Three years ago we accepted the suggestion of Dr. R. B. Anderson that we aid the State Medical Association in securing endowment funds for the Medical Library. The Woman's Auxiliary Library Endowment Fund has now reached more than $2,400. One thousand of this was given by Mr. and Mrs. G. A. Ray, parents of Mrs. S. F. Harrington, as a memorial to their daughter, Romayne Ray. The second thousand was a gift from the past presidents of the State Auxiliary. The remainder came as gifts from the county auxiliaries. As this fund becomes better known we believe the gifts from the counties will be larger.

We could not be a group of doctors' wives without having benevolent projects in our program. The Auxiliary maintains three philanthropic funds. Two of these are student loan funds, to assist worthy medical students through the last two years of medical school. These two student loan funds now amount to over $13,000. Our third fund is the Memorial Fund, to assist needy doctors' families. This is a gift fund. It has now reached nearly $8,000. This was raised largely by sending gifts to the Memorial Fund instead of flowers to funerals.

For many years all county auxiliaries have put into their programs two special days, two days that have become Auxiliary's most cherished traditions: Doctor's Day and Public Relations Day.

Doctor's Day is set aside to honor our doctors, not because they are our husbands, but because we, more than any other group, realize that the doctor's greatest joy is the joy of healing, and understand that the doctor's time belongs not to us but to the public he

serves. The Bible says, "He that is greatest among you shall be your servant." So we have Doctor's Day to honor those who have achieved true greatness through their service to humanity.

On Public Relations Day, the Auxiliary opens its meeting to other women's organizations, to hear recognized authorities speak upon health topics. The purpose is to mold public opinion upon matters of health education, and to establish a friendly relationship with other women's groups. San Antonio, at her Public Relations Day, had a woman lawyer speak to the club, P. T. A., and church women of her city upon the dangerous legislation that would socialize medicine; Houston had this same program last year. Many counties have had this type of Public Relations Day, with a local doctor or doctor's wife as the speaker. Dallas doctors' wives spoke before twelve organizations upon the subject of political medicine.

Perhaps the most important work the Auxiliary did this year was its effort to combat adverse medical legislation. The Legislative Chairman conducted a poll tax campaign over the state, to see that every one interested in protecting the public health paid his poll tax and stood ready to vote against those candidates who would lower our medical and health standards. Twenty counties responded to our request to send letters to their Congressmen. Houston doctor's wives wrote one hundred and thirty letters at one time, all of which were answered. A Chicago doctor mentioned this before the National Conference of State Presidents in Chicago last December. Many auxiliaries aided in the distribution of literature concerning health legislation. Marlin, Galveston, and Dallas, each distributed more than a thousand pamphlets. Members of all auxiliaries were requested to visit their Congressmen while they were at home during the holidays. The El Paso women made seven different calls on their Congressmen.

When the President of the Auxiliary to the American Medical Association sent word that the Y. W. C. A planned to endorse the Wagner-Murray-Dingell Bill at its National Convention in March, every Y. W. C. A. in Texas was contacted and the convention delegates given literature presenting the doctors' point of view. The Y. W. C. A. Health Education Committee, at its preconvention meeting, was greatly surprised to learn that the Wagner-Murray-Dingell Bill did not have the backing of the medical profession, and the committee tabled the matter as too controversial to bring before the convention. Many other large women's groups are also ignorant of the wide implications of this bill. Caroline Ware, of the American Association of University Women, stated that her organization of 80,000 members is supporting the National Health Bill, S. 1606; however, she admits that her organization has not passed upon the compulsory feature of the bill. There are hundreds of doctors' wives who belong to the American Association of University Women.

In closing, I make the request that every county medical society discuss its program with its auxiliary, that it may be of greater service. If the Auxiliary has helped the medical profession this year, the credit is not mine, but belongs to you doctors, for it is you who have selected these wonderful women to be your wives. (Applause.)

Chairman Wall: Ladies and gentlemen, the eightieth President of the State Medical Association of Texas, Dr. H. F. Connally, of Waco. (Applause, the audience standing.)

President Dr. H. F. Connally, of Waco, then delivered his annual address, which address appears in the Original Article Section of this number of the JOURNAL (page 70).

Chairman Wall: As Chairman of the General Arrangements Committee, I now turn the meeting over to President Connally.

The meeting was then recessed until 10:45 a. m.

The meeting was called to order by the President, Dr. H. F. Connally, at 10:45 a. m.

Dr. James L. Wilson, of Ann Arbor, Mich., guest of the Section of Pediatrics, delivered an address on the subject of "Intestinal Obstruction in Infants of a Functional Nature, Probably Due to Congenital Absence of Certain Elements in the Autonomic Nervous System."

Dr. Nicholson J. Eastman, of Baltimore, Md., guest of the Section on Obstetrics and Gynecology, delivered an address on "Prematurity from the Obstetrical Viewpoint," which address will be published in an early number of the JOURNAL.

President Connally: I see the Honorable Beauford Jester in the audience. I would like to present him to you. He is a candidate for Governor. His stand on our medical program is well and favorably known.

REMARKS OF HONORABLE BEAUFORD JESTER

Mr. Beauford Jester, of Corsicana: I am deeply appreciative of this opportunity at this time to salute a great and honorable profession.

In my opinion, next to the ministry, the calling of medicine is the highest vocation a man can follow. I think my profession of the law and that of the teaching profession crowd each other for third place.

I want to salute the doctors of Texas for a magnificent job during the war. They were the most overworked men I know anything about, and theirs was a great contribution to the war effort, both in the armed forces and on the home front.

I feel a close kinship to the medical profession, because I very nearly was a doctor. As a matter of fact, I was sent to the University of Texas to take a premedical course, and I was to be not only a doctor but a partner of my uncle, Dr. Clay Johnson, of Fort Worth.

But there seemed to develop an allergy between some of the different scientific subjects and me, and in my junior year I switched.

Your President has introduced me as a candidate for governor. I am mindful of the fact that it would not be appropriate for me to make political statements and take advantage of the courteous introduction such as he has extended me.

One of the things that perhaps you are interested in, in my opinion should not be political. I am talking about the federal plan to regiment the medical profession in Texas and in the other states of the union. My position on that matter was clearly stated in my opening speech last Saturday; that in my opinion it is unwise, and that I will oppose the use of any state funds in any program of socialized medicine or compulsory life insurance. (Applause.)

I want Texas to handle its own medical problems, and any governor of Texas who is wise will lean heavily upon the members of your association and your profession.

It is a pleasure to be here, and to have had the opportunity of making this brief statement to you. I hope you will have a happy, profitable, and enjoyable meeting here in Galveston. I thank you. (Applause.)

At 12:00 o'clock, noon, adjournment was had until 3:15 p. m., Wednesday, May 8.

WEDNESDAY, MAY 8, 1946

Second General Meeting

The Second General Meeting was called to order by the President, Dr. H. F. Connally, in the Ballroom, Hotel Galvez, Galveston, at 3:15 p. m., May 8, 1946.

Mr. J. C. Ketchum, Chicago, Ill., guest of the State Medical Association, delivered an address on "Prepayment Medical Care."

Dr. Lee D. Cady, Branch Medical Director, Tenth Branch, United States Veterans Administration, of

Dallas, guest of the State Medical Association, delivered the following address:

REMARKS OF DR. LEE D. CADY

I am the new Branch Medical Director of the Tenth Branch of the U. S. Veterans Administration. That Branch comprises Texas, Louisiana, and Mississippi. I am delighted to have this opportunity to speak to you for about three minutes.

The new law, Public Law 293, creates a new department of medicine and surgery in the Veterans Administration. In that law responsibility for the quality, and I might say the quantity, of care of the veteran is put back in the laps of the medical profession. It is true that it does so indirectly, but that is what is done. We are not able to get sufficient doctors, full time doctors, to take care of our problems now or for many years to come, so we are bringing the patients to the doctors, in contrast with what we have done before.

The doctors, dentists, and nurses are taken from the civil service, although they are allowed to retain civil service retirement privileges. They are given better pay. The doctor, for example, is rated according to the job he is expected to fill.

Hospitals and out-patient departments are being affiliated with teaching centers. They become teaching hospitals or teaching clinics, such as you went through when you were medical students, or when you were interns and residents.

I do not mean that veterans are going to be used for teaching material in the way charity patients are used. I do not mean that. But residents are being taught in these hospitals.

Another thing which may concern you more than just what I have been describing, is the change that is contemplated in the so-called system of fee designated physicians. We have that, and have had it for years. A fee designated physician is selected by the Veterans Administration on application, as a rule, of the physician himself. He is paid a fee which has been set up by the Veterans Administration.

It is realized that the fee schedule is not equitable for all states and that something should be done about it.

It is also recognized that we should do something to get home town care for the veteran. We do not have enough hospitals and we do not have enough personnel. We are having to dump it all right back into the laps of the medical profession, where it quite properly belongs. So, we must modify this fee designated system to something you can help with.

The so-called Michigan Plan you have been hearing about is something I hope your state will adopt; not necessarily the exact plan, or the exact fee schedule, but something similar to it. Your State Medical Association should designate the quality and, I might say quantity, of doctors who will take care of the veteran patients. You should have something to say about the hospitals, when we cannot handle them ourselves.

So it means that your Association is now having an opportunity to select these doctors from your own members, and an opportunity to take up and consider a proper fee schedule for the state of Texas.

A third organization will come into this picture, usually because the State Medical Association is not a business organization and does not care to handle accounts for doctors. Some other organization, a Blue Cross organization, usually, has been selected elsewhere. You have such an organization in this state now. That is the organization that will take care of the accounts and pay the doctors for the service they have rendered the patients.

Your Secretary has very kindly accorded me the privilege to distribute some green fact sheets which I have. They will be on the table by the door. They will tell you something about the Veterans Administration in which you may be interested.

I am happy to have had this opportunity to speak briefly to you. Thank you very much. (Applause.)

Dr. M. Herbert Barker, of Chicago, Ill., guest of the Section on Medicine, then delivered an address on "Some Uses and Abuses of the Thiocyanates," which address will be published in an early number of the JOURNAL.

Dr. Wiley D. Forbus, of Durham, N. C., guest of the Section on Clinical Pathology, then delivered an address on "Coccidioidomycosis, a Civilian and Military Problem—A General Pathological Study Based Upon Experiences with the Disease in the Armed Forces."

Dr. Daniel Blain, of Washington, D. C., guest of the State Medical Association, delivered an address on "Neuropsychiatry in the Veterans Administration."

There being no further business to come before the General Meeting adjournment was had.

Memorial Services

The general meeting for Memorial Services was called to order by the President, Dr. H. F. Connally, in the Ballroom, Hotel Galvez, Galveston, at 5:15 p. m., May 8, 1946.

President Connally: I will now turn the meeting over to Dr. W. L. Crosthwait, of Waco, Chairman of the Committee on Memorial Exercises.

Chairman Crosthwait: We approach this hour according to our traditional and time honored custom.

Dr. Wil R. Johnson, pastor of the First Presbyterian Church of Galveston, delivered the invocation.

"One Sweetly Solemn Thought," was sung by Mr. Glenn Gordon, accompanied by Mr. Victor Neal, both of Galveston.

Mrs. P. R. Denman, of Houston, delivered the memorial address and read the roll call of deceased members for the Woman's Auxiliary. Her talk is published as a part of the Transactions of the Woman's Auxiliary, to be published in the July, 1946, JOURNAL.

Chairman Crosthwait: The roll call of deceased physicians, 1944 and 1945.

Secretary Taylor: As pointed out by Dr. Crosthwait, this roll call will cover two fiscal years, from May, 1944, to May, 1946. It is divided into two parts. First are those who died while they were members of this Association. The second part consists of those who died while not members but who were considered in the same category from an ethical and professional standpoint. One hundred and thirty-eight members died during the past two years, and one hundred and thirty-two nonmembers.

The following are names of members who died:

DECEASED MEMBERS—1944-1945 AND 1945-1946

Allen, Dr. George W., Jr., San Antonio.
Anthony, Dr. E. Y., Omaha.
Applewhite, Dr. Scott C., San Antonio.
Austin, Dr. H. M., Laredo.
Aynesworth, Dr. Kenneth H., Waco.
Ballard, Dr. Arthur E., Laredo.
Bass, Dr. T. B., Abilene.
Beech, Dr. George D., Rio Hondo.
Bellamy, Dr. Charles H., Dallas.
Belote, Dr. John W. H., Wills Point.
Biscoe, Dr. Pat, Houston.
Block, Dr. Cecil, Dallas.
Brown, Dr. Harry H., Yoakum.
Burg, Dr. S. S. (Hon.), San Antonio.
Burton, Dr. Edwin L., McKinney.
Butler, Dr. George L. (Mil.), Beaumont.
Cannon, Dr. I. F., Mart.

Clements, Dr. Stanley C., Houston.
Cooper, Dr. Covert B., Grand Prairie.
Craige, Dr. Branch, El Paso
Crain, Dr. Charles E. (Mil.), San Antonio.
Crook, Dr. L. F., Bellevue.
Crumpler, Dr. W. E., Port Arthur.
Daniel, Dr. Joseph E. (Hon.), Houston.
Daughety, Dr. Jewel, Brownwood.
Davidson, Dr. Wilson T., Belton.
Dunnam, Dr. Thomas E., Houston.
Edwards, Dr. L. L., San Marcos.
Ellis, Dr. Lucius M., Houston.
Etter, Dr. William F., Rogers.
Evans, Dr. E. O., San Antonio.
Fowler, Dr. C. F., Galveston.
Frobese, Dr. Joseph R., Austin.
Fuquay, Dr. Zack C., Mount Vernon.
Furman, Dr. John M., Fort Worth.
Gantt, Dr. Albert M., Houston.
Gilbert, Dr. G. H., Austin.
Gilbreath, Dr. S. Frank, San Antonio.
Gober, Dr. O. F., Temple.
Gough, Dr. H. W., San Antonio.
Grant, Dr. William A., Bardwell.
Green, Dr. F. J., Mineola.
Gullette, Dr. J. Frank, Sr., Austin.
Guy, Dr. William H., Dublin.
Hairston, Dr. J. T., San Antonio.
Hale, Dr. Richard A., Houston.
Hall, Dr. J. L. (Mil.), Stanton.
Hardin, Dr. Dexter H., Dallas.
Hargrave, Dr. Robert L. (Hon.), Wichita Falls.
Harris, Dr. Wyly H., Raymondville.
Hill, Dr. Charles C., Grapeland.
Honea, Dr. Thomas C., Cleburne.
Howard, Dr. Isaac M., Ranger.
Hyder, Dr. D. C., Donna.
Irwin, Dr. H. C., Orange.
Jackson, Dr. John D., Kerrville.
Jackson, Dr. Walter L., Ranger.
James, Dr. A. Judson (Hon.), Houston.
Jeter, Dr. T. M., Fort Worth.
Keyes, Dr. Claude T., San Angelo.
Kinsell, Dr. Benjamin, Dallas.
Kirby, Dr. Floyd F., Waco.
Kirkpatrick, Dr. S. B. (Hon.), Taylor.
Kleberg, Dr. Walter, Galveston.
Kuehne, Dr. Henry, Coupland.
Lackey, Dr. W. C., Fort Worth.
Laidacker, Dr. Nelson E., China.
Lewis, Dr. George L., San Angelo.
Long, Dr. William F., Sulphur Springs.
Lovejoy, Dr. Edward F., Corpus Christi.
Lovelace, Dr. Carl, Waco.
Lumpkin, Dr. S. Hugh (Mil.), Amarillo.
Lynch, Dr. Kevin D., El Paso.
McCreary, Dr. J. S., Buffalo.
McDaniel, Dr. Alfred C., San Antonio.
McDonald, Dr. J. Francis, Hillsboro.
McKown, Dr. James S. (Hon.), Osceola.
McMurray, Dr. J. R., Galveston.
Macune, Dr. J. W., Ballinger.
Manney, Dr. John E., San Antonio.
Mathews, Dr. Claud A., Austin.
Mathews, Dr. W. J., Abilene.
Montgomery, Dr. Jason E., Weslaco.
Moore, Dr. Stephen D. (Hon.), Van Alstyne.
Morris, Dr. E. T., San Benito.
Munter, Dr. Craig W., Fort Worth.
Nooe, Dr. John F., Boerne.
Norman, Dr. James E., Trenton.
O'Farrell, Dr. J. Mark (Hon.), Houston.
Ogilvie, Dr. H. H., San Antonio.
Pabst, Dr. Oscar C. (Hon.), Tyler.
Parsons, Dr. William H., San Antonio.
Partain, Dr. Robert A., San Antonio.
Purdie, Dr. Robert M., Houston.
Ramsey, Dr. John Bruce, Forest.
Randall, Dr. Edward, Sr. (Emer.), Galveston.
Reger, Dr. Howard J., Vernon.
Rentfro, Dr. James L., Brownsville.
Roddy, Dr. Louis H., Waco.
Rosebrough, Dr. Frank H., San Antonio.
Rosser, Dr. Charles M. (Hon.), Dallas.
Russ, Dr. Stirling E., San Antonio.
Russell, Dr. Buford A., Sherman.
Ryan, Dr. W. E. (Mil.), Midland.
Sauvignet, Dr. E. H. (Hon.), Laredo.
Schuster, Dr. Louis C., Houston.
Sewell, Dr. John H., Fort Worth.
Shytles, Dr. Henry W. Grady, Abilene.
Singleton, Dr. G. T., Wichita Falls.
Smith, Dr. Newton J., Anson.
Stafford, Dr. Brooks, Angleton.
Stanfield, Dr. J. A. (Hon.), Fort Worth.
Stoeltje, Dr. Edward C., Rosebud.
Stricklin, Dr. Calvin G., Clarendon.
Sullivan, Dr. Rufus A., Dallas.
Sutton, Dr. Dewey, San Angelo.
Swan, Dr. H. A., Abilene.
Swindell, Dr. John W., Greenville.
Taylor, Dr. Charles C., Cooper.
Taylor, Dr. Judson L. (Mil.), Houston.
Terrill, Dr. J. J., Dallas.
Tiner, Dr. Edgar L., Crystal City.
Tumbleson, Dr. Talbot A., Beaumont.
Turner, Dr. Stephen T., El Paso.
Usry, Dr. R. S., Dallas.
Walker, Dr. Marcellus A., Paris.
Watts, Dr. G. Graham (Hon.), San Antonio.
Weaver, Dr. Glenn S., Big Spring.
Webb, Dr. J. G., Mercedes.
Weems, Dr. Marcus A., East Columbia.
Werley, Dr. Gottlieb, El Paso.
White, Dr. Adair W., Houston.
White, Dr. W. P., Henderson.
Wilcox, Dr. C. A., Wichita Falls.
Wolf, Dr. William M., San Antonio.
Wright, Dr. Robert E., Dallas.
Yantis, Dr. George R., Brownsville.
York, Dr. J. B., Houston.

The following are the names of reputable physicians who died while not members:

DECEASED NONMEMBERS—1944-1945 AND 1945-1946

Adamson, Dr. O. D., Sabine.
Allen, Dr. James S., Emory.
Arthur, Dr. T. L., Kingsville.
Baker, Dr. A. M., Carthage.
Bartlett, Dr. Glenn E., Sr., Falfurrias.
Biggs, Dr. W. D., Lometa.
Bills, Dr. Robert C., Lockhart.
Blackburn, Dr. R. Lee, Carrollton.
Blair, Dr. Charles M., Wharton.
Bowes, Dr. C. C., Greenville.
Breeding, Dr. A. L., San Antonio.
Bristow, Dr. Prentice M., Stanton.
Brookes, Dr. Robert C., Waelder.
Brown, Dr. H. Houston, Kingsville.
Bryan, Dr. R. T., San Antonio.
Brymer, Dr. William G., Bandera.
Buchanan, Dr. John T., Fort Worth.
Burleson, Dr. E. M., Richland Springs.
Calvert, Dr. William J., Dallas.
Carpenter, Dr. Jacob C., Clifton.
Carter, Dr. W. S., Auburndale, Mass.
Chambers, Dr. B. F., Port Arthur.
Chilton, Dr. L. W., Sr., Goliad.
Clark, Dr. Adolphus F., Burleson.
Cloud, Dr. W. O., Boling.
Craddock, Dr. L. L., Junction.
Creagan, Dr. Martin V., Fort Worth.
Curby, Dr. T. R. (Mil.). Houston.
Curry, Dr. Thomas G., Franklin.
Davidson, Dr. J. C., Bryan.
Davis, Dr. F. L., Waxahachie.

Davis, Dr. J. D., Roby.
Deter, Dr. Dwight M. (Mil.), Austin.
Drake, Dr. Charles W., Brownwood.
Eargle, Dr. Henry C., Dublin.
Edge, Dr. John (Mil.), Bryan.
Erwin, Dr. John H., Bandera.
Faulkner, Dr. Sidney A., Whitney.
Fleming, Dr. J. E., Marshall.
Foster, Dr. E. C., Denton.
Foster, Dr. Robert T., Groom.
Frazier, Dr. John R., Fort Worth.
Freeman, Dr. Charles E., San Antonio.
Gardner, Dr. Lucy W., San Antonio.
Gill, Dr. John M. F., Waco.
Gose, Dr. J. C., Krum.
Graves, Dr. Joseph H., Houston.
Guillory, Dr. Thomas A., Groesbeck.
Halcomb, Dr. V. S., Brownwood.
Hambright, Dr. J. G., Roby.
Hanchey, Dr. Jesse M, Caddo Mills.
Hancock, Dr. Ernest A., Ranger.
Hanson, Dr. W. S., San Antonio.
Harris, Dr. John R., Everman.
Hasten, Dr. Carroll, Denton.
Hill, Dr. Guy Eugene, Houston.
Holderness, Dr. G. W., Commerce.
Holmsley, Dr. G. W., Comanche.
Hurley, Dr. H. P., San Angelo.
Iford, Dr. Daniel W., McAllen.
Irion, Dr. J. W., Fort Worth.
Jones, Dr. Billie M., Bridgeport.
Jones, Dr. J. H. B., Petrolia.
Kellam, Dr. A. J., Canton.
Kenney, Dr. John W., San Antonio.
King, Dr. George T., Elgin.
Knight, Dr. J. R., Eddy.
Kolb, Dr. Harmon J., Hargill.
Kubricht, Dr. Theo, Wallis.
Lacy, Dr. A. P., Mount Enterprise.
Lanius, Dr. George Lee, Beaumont.
Lee, Dr. Benjamin F., Temple.
Livingston, Dr. J. J., Tyler.
Longino, Dr. Hugh M., Mineral Wells.
Lovelace, Dr. J. D., Waco.
Loving, Dr. Joseph H., Wellington.
Lynch, Dr. Treau P., Como.
McAuliffe, Dr. P. J., McAllen.
McCollum, Dr. Edmond O., Tyler.
McCuan, Dr. John Milton, Farwell.
McDaniel, Dr. Irvin H., Alto.
McGee, Dr. John Franklin, May.
McPhail, Dr. Gus R., Tomball.
Magee, Dr. L. S., Hamlin.
Maness, Dr. Marquis H., Roxton.
Manning, Dr. William N., Richardson.
May, Dr. J. C., Perryton.
Merrell, Dr. C. W., O'Donnell.
Miller, Dr. James K., Sonora.
Miller, Dr. Samuel A., Longview.
Milliken, Dr. Gibbs, Houston.
Mitchell, Dr. Karen (Mrs. A. L.), Orange.
Montgomery, Dr. G. L., West.
Moore, Dr. Willis M., Sipe Springs.
Moorhead, Dr. John D., De Leon.
Morris, Dr. I. J., Dallas.
Morrow, Dr. H. C., Austin.
Morton, Dr. Albert S., Bay City.
O'Barr, Dr. John T., Big Spring.
Ogle, Dr. J. M., Frisco.
Osterhout, Dr. Paul, San Antonio.
Powell, Dr. Edwin T., San Antonio.
Price, Dr. Luke W., Graham.
Reed, Dr. Allen T., Toyah.
Reed, Dr. Volney E. H., Austin.
Rogers, Dr. Lieuen M., Fort Worth.
Rogers, Dr. Marshall J. (Mil.), Rule.
Sanders, Dr. William E., Winters.
Scott, Dr. Jack (Mil.), Galveston.
Seagraves, Dr. Samuel L., Era.
Smith, Dr. Herman C., Liberty.
Smith, Dr. W. A., San Antonio.
Snyder, Dr. J. W., Childress.
Sparks, Dr. I. J., Sudan.
Stehouwer, Dr. Orrie W., Galveston.
Strube, Dr. William E. (Mil.), Fort Worth.
Sullivan, Dr. Charles F., Houston.
Sutherland, Dr. W. A., Flat.
Tabb, Dr. Luther M., Mount Pleasant.
Taylor, Dr. Green Benjamin, Cameron.
Taylor, Dr. John S., Mount Pleasant.
Thomas, Dr. Hubert J., Dallas.
Thompson, Dr. Isaac N., Mathis.
Walker, Dr. William Henry, Fairfield.
Ward, Dr. L. M., Odessa.
Ward, Dr. W. H., Cumby.
Wickens, Dr. Billy True (Mil.), Strawn.
Willbern, Dr. David Y., Runge.
Williams, Dr. H. E., San Antonio.
Williams, Dr. James, Dallas.
Williams, Dr. S. J., Telephone.
Young, Dr. James W., Fort Worth.

Dr. W. L. Crosthwait, of Waco, then delivered the Memorial Address for Physicians, which address appears elsewhere in this number of the JOURNAL (Page 72).

Mr. Glenn Gordon, accompanied by Mr. Victor Neal, both of Galveston, then sang "Crossing the Bar."

Dr. Wil R. Johnson then delivered the benediction.

The Memorial Services were concluded, and the meeting was adjourned at 6:15 p. m.

Minutes of the House of Delegates
Second Meeting

The House of Delegates was called to order by the President, Dr. H. F. Connally, Wednesday, May 8, at 8:00 p. m., in the Basement Room, Hotel Galvez, Galveston, with an attendance of 92 delegates.

The Reference Committee on Credentials reported, as follows:

FOURTH REPORT OF REFERENCE COMMITTEE ON CREDENTIALS

Dr. Hall Shannon: The Reference Committee on Credentials reports 92 delegates seated and present here tonight.

On motion of Dr. A. R. Shearer, seconded by Dr. Schenewerk, the House voted to dispense with the roll call.

The Secretary presented a letter from Alpha Epsilon Delta, Honorary Premedical Fraternity, Texas Alpha Chapter, dated Austin, Texas, May 6, 1946, inviting the members of the medical and allied professions to attend the statewide meeting and banquet of physicians and premedical students to be held on June 1, 1946, at 7:00 p. m., in the Ballroom of the Stephen F. Austin Hotel.

Dr. John T. Moore, of Harris, at the request of Dr. W. M. Brumby, of Houston, presented resolution requesting that steps be taken to seek necessary action by the Congress of the United States to have the name of Dr. Roger Post Ames, represented on the Roll of Honor created by Act of Congress, approved February 28, 1929.

The resolution was referred to the Reference Committee on Resolutions and Memorials.

Dr. John T. Moore, of Houston, at the request of Dr. Russell F. Bonham, of Houston, presented a resolution in behalf of anesthesiology, and the reso-

lution was referred to the Reference Committee on Scientific Work.

Dr. Robert E. Parrish, of San Antonio, presented a resolution recommending change in the state law regarding compensation for injured federal civil service employees and the selection of physicians. The resolution was referred to the Reference Committee on Reports of Officers and Committees.

The Secretary presented a communication from the Section on Clinical Pathology recommending that the Medical Practice Act be so changed and amended that a license to practice medicine would be required for anyone practicing pathology and other diagnostic specialties. The communication was referred to the Reference Committee on Reports of Officers and Committees.

President Connally then delivered his message to the House of Delegates, as follows:

The President's Message

During the two turbulent years of my presidential administration I have had the opportunity to view our organization from all angles. In taking the very first step into the sanctuary of our holy organization, I found some of our "would be" Pontius Pilates, with many years of leadership in this organization, attempting to disregard the By-Laws by which our proceedings have been governed for more than forty years. Apparently, they were of the opinion that they could use whatever means they found necessary to defeat those who sought to follow their own ideas and privileges in the leadership of this Association. From their long years of dictation in the procedures of this House, they acted as though they had become the interpreters of our Constitution and By-Laws, and could model them to fit any occasion that might arise in their efforts to dominate leadership in the proceedings of this House of Delegates.

You who were present in the House of Delegates meeting in Dallas on May 11, 1944, will remember how I was outraged and humiliated by the attempt made to break down the provisions of our By-Laws in their effort to usurp the authority that belonged to the President-Elect in the appointments to be made on certain committees. That experience caused me to make a close study of our By-Laws, and there are several changes that should be made.

There should be a careful study made by our Committee on Constitution and By-Laws, and it should prepare the proper changes to be made and bring its recommendations before this House at its next regular meeting.

The greatest need of this Association today is for young, vigorous leadership. There are too many men who have grown old and are in their dotage in the leadership of this organization. Some of them have rendered faithful and valuable service for many years, and should have been retired before their leadership began to wane.

To clear that situation, I recommend that our By-Laws be made to provide that no person shall hold an office in this organization for a longer period than ten years, and that no one past the age of 65 shall be eligible to hold elective office.

I further recommend that this State be divided into five zones, each zone to cover three Councilor Districts, a Central Zone, North Zone, West Zone, and a South Zone, and there shall be one member of the Board of Trustees from each of these zones, and they shall be elected by the House of Delegates after they have been recommended by the delegates from their respective zones.

The Councilors shall be elected by the House of Delegates after they have been chosen by their own District Medical Society.

There has been a great deal of discussion in the past two years concerning the changes to be made in our headquarters office in Fort Worth. On this suggestion I will say that much caution should be exercised in whatever change is made. Our present Secretary has rendered long and valuable service, and, out of his experience, has acquired knowledge that only time and experience can provide. There is no way to escape the necessity of getting new help in our office in the near future. It will be unwise to make an abrupt change in the affairs of the office. It will be necessary to educate someone to take over the leadership in the office. In my opinion, it will be wise to employ an expert secretary, who is a non-medical man, to take charge of the secretarial work in the office. At the same time, we should engage the services of a well-educated medical man, one who is experienced in the actual practice of medicine, to edit the Journal, and to see that the work in the office is properly coördinated. The present office force will be able to render valuable service in carrying out the duties of the office.

I further recommend that some changes be made in the Public Relations Committee. The President-Elect should automatically become Chairman of the Committee; the Board of Councilors should be his adviser; the detail work of the Committee should be done by someone in the office at Fort Worth. The President-Elect and the Public Relations expert, with the assistance of the President, can carry the work of the Committee to the various districts and larger county societies of the state to a much better advantage than it can be done by the average hired hand. They will attract a larger attendance at the meetings, and will make a better impression as they travel over the state. Such a change will give both the President and President-Elect the opportunity to appear before all district and larger county medical societies, which will very much magnify the work of your President and President-Elect. With the present set-up, the Public Relations Committee has taken from the President the only opportunity he has to get before the various medical societies of the state.

The proposed changes which have been promulgated by the Public Relations Committee in the Texas Medical Practice Act should have your careful consideration. So far as I know, they have not mentioned the changes that were adopted by the Legislative Committee in its meeting in Austin in January. When these two proposed changes are brought before this body, they should have a full and free discussion, and a very careful study should be made before the matter is disposed of.

The Texas Medical Practice Act provides that the State Board of Medical Examiners shall be composed of twelve physicians to be appointed by the Governor from the four schools of medicine; namely, the Regular School of Medicine, Eclectic School of Medicine, Homeopathic School of Medicine, and Osteopathic School of Medicine. The Act provides that no one school shall have majority of the members of the Board.

The subjects on which the examinations are to be given are twelve in number, that is, six basic science subjects, Physiology, Anatomy, Chemistry, Histology, Pathology, and Bacteriology; and six clinical subjects, Surgery, Obstetrics, Gynecology, Diagnosis, Public Health and Hygiene, and Medical Jurisprudence. This was a compromise measure, and it was passed at that time with the view of permitting those who were not using medicine in their treatment to continue in their customary treatment. The idea was for them to become proficient in the basic science subjects, which would enable them to make an intelligent diagnosis, and they would probably be able to institute an intelligent method of treatment.

At the present time, the osteopaths are claiming to be doctors of medicine, and are practicing med-

icine after a fashion as it is taught by the Regular School of Medicine. It is my opinion that the Texas Medical Practice Act should be amended by the establishment of a Basic Science Board composed of three college professors selected from the professors teaching these subjects in the universities of the state that rank among the best schools, such as the University of Texas at Austin, A. & M. College at College Station, Rice Institute at Houston, Texas Tech at Lubbock; two doctors selected from the three medical schools in Texas, who shall be the examiners on the Board for the subjects of Pathology and Anatomy, and the other three members of the Board, who will be the examiners on the subjects of Chemistry, Physiology, and Bacteriology.

The present law, which now reads that no school shall have a majority of the members on the State Board of Medical Examiners, should be amended to read that the membership on the State Board of Medical Examiners shall be in proportion to the ratio of the number of licensed physicians in each school in the State of Texas, and that the membership on the Board of Medical Examiners should be reduced from twelve to nine. The following subjects will be required for the Board's examinations: Histology, Medicine, Physical Diagnosis, Materia-Medica and Therapeutics, Surgery, Obstetrics, Gynecology, Public Health and Hygiene, Medical Jurisprudence.

In closing, I wish to say that I have full confidence in both the integrity and ability of this House of Delegates to do the things that are to the best interest of this Association when they know the facts. It is not my desire to leave the impression that I am displeased with the action of this body, or that I am unappreciative of the honor you did me in electing me President of this Association. What really has happened is that my rebuffs have made me more determined to say what I really believe should be done to improve the work of our Association instead of trying to toss bouquets at some of those who have so long been in the position to dictate to this House what they should do. (Applause.)

The address was referred to the Reference Committee on Reports of Officers and Committees.

Dr. L. B. Jackson, of San Antonio, Chairman of the Reference Committee on Reports of Officers and Committees, then presented the report of the committee, as follows:

FIRST REPORT OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND COMMITTEES

1. *Report of Board of Councilors:* The Board of Councilors, like every other committee and group, has of necessity done its best under existing conditions. With more time, will come greater opportunity for service.

On motion of Dr. Jackson, seconded by Dr. Davis, that portion of the report was adopted.

2. *American Academy of Pediatrics Survey:* Your committee feels that every effort which will furnish more knowledge to be used for better service to the sick should receive the blessings of this Association. However, this survey is being made and financed jointly by agencies not proven coöperative in the past. Until such agencies are divorced by this survey, we feel that we should not entangle the House of Delegates with formal endorsement. We recommend that this matter be left open, pending action by the State Pediatrics Society.

It was moved by Dr. Jackson, and seconded by Dr. T. C. Terrell, that the recommendation of the committee be adopted.

Dr. C. O. Terrell: We have got to have help in tabulating these statistics that we cannot get without spending an immense amount of money. We are trying to borrow some tabulating machines that will save expense. We are not coöperating with the agencies mentioned in the report, and we do not believe in a lot of things they are doing. We are not putting ourselves under obligation to the Children's Bureau in Washington, D. C., or any other New Deal agency.

Dr. Jackson: Let me read the basis of our statement:

"The Academy, together with two coöperating government agencies . . . including statistical requirements." That is the reason we have seen fit to advise against formal endorsement by this Association.

The vote was taken, and that portion of the report was adopted.

3. *Report of Legislative Committee:* Your Committee considers this report one of the most outstanding ever given to this Association. The labors of the committee have been arduous and their achievements for health legislation great. We would suggest that recommendation 4 (in the report) be enlarged to utilize the Public Relations Committee, to insure the achievement of this recommendation. The report is informative not only of achievement but as to strategy employed. The Legislative Committee must of necessity play a game, when to show their hand or disclose their strategy, would often defeat their purpose. We therefore feel that we, as members of the medical profession, must of necessity, in the face of discouraging appearances, repose confidence in our committees, especially so our Legislative Committee, and that we be slow in forming conclusions or indulging in criticism, because much harm can easily be done our cause and our legislative program by the appearance of a divided profession. It is unfortunate that differences and discord must at times be unavoidable. We would recommend that Father Time be given an opportunity to bind up the wounds and make them less painful.

On motion of Dr. Jackson, seconded by Dr. Powell, that portion of the report was adopted.

4. We recommend the adoption of the following resolution, introduced by Dr. F. J. L. Blasingame, which we consider as a part of the Report of the Legislative Committee, because of its reiteration of a recommendation in the Report of the Legislative Committee:

RESOLUTION ENDORSING BASIC SCIENCE LAW

Whereas, our Legislative program, which includes a Basic Science Law as written by the General Attorney of the State Medical Association of Texas, Mr. C. T. Freeman, of Sherman, Texas, has been approved unanimously three times by the Executive Council of this Association, and twice by our House of Delegates, and was introduced in the 48th session of the Texas State Legislature, in 1943, therefore be it

Resolved that this House of Delegates direct the present Legislative Committee to introduce the same medical legislation in the next Texas State Legislature, at the earliest possible date after its convening, and work for the passage of the legislation.

On motion of Dr. Jackson, seconded by Dr. Ryan, that portion of the report was adopted.

5. *Report of the Executive Council:* We have studied carefully this report, and feel that those composing the Executive Council have worked hard on the matters covered and have, therefore, first hand knowledge of the problems involved. We should follow their advice and adopt the report without comment.

On motion of Dr. Jackson, seconded by Dr. W. D. Jones, that portion of the report was adopted.

6. *Report of the Committee on Liaison, Lone Star State Medical, Dental, and Pharmaceutical Association:* It is to be hoped that our Association can, with the passage of the years, render more and more service to the Negro physicians of the state. By that means we shall help solve a problem that promises to be more and more serious—the relationship of the races. We wish to advise the early establishment of a medical school for Negroes in Texas.

On motion of Dr. Jackson, seconded by Dr. J. W. David, that portion of the report was adopted.

7. *Secretary's Report:* It appears to this Committee that the State Secretary's Office "has done it again!"—a good job under the disadvantages of Dr. Anderson's illness and absence from the office a part of the time. We wish for Dr. Anderson a speedy return to good health.

In line with the recommendation of the State Secretary dealing with the election of officers, we wish to recommend that the tenure of office of elective officers be terminated with this administration. Inasmuch as a precedent was set in 1944 and 1945 in the continued tenure of officers and committees, we recommend that if through public calamity it becomes impossible to hold a regular meeting of the House of Delegates, a like procedure be followed until the next succeeding annual meeting, and if necessary to legalize such action, that our Constitution be so amended.

On motion of Dr. Jackson, seconded by Dr. Travis, that portion of the report was adopted.

On motion of Dr. Jackson, seconded by Dr. Hudgins, the report as a whole was adopted.

Respectfully submitted,
L. B. Jackson, Chairman,
Victor E. Schulze,
L. H. Denman,
S. D. Whitten.

Dr. A. A. Ross, of Lockhart, Chairman of the Reference Committee on Resolutions and Memorials, then presented a report by the Committee as follows:

First Report of Reference Committee on Resolutions and Memorials

Your Committee on Resolutions and Memorials has had under consideration the following resolution from the Jefferson County Medical Society:

RESOLUTION ON WAGNER-MURRAY-DINGELL BILL

Whereas, S. B. 1606, the so-called Wagner-Murray-Dingell bill, sets up a panel system to provide medical care through compulsory health insurance, thereby regimenting both patients and doctors under bureaucratic control, and

Whereas, the Surgeon General of the United States Public Health Service would, in effect, have dictatorial power over both patient and doctor through his authority to establish fees, allocate patients, select physicians or withdraw funds, and

Whereas, the cost of administration for such a system of federally supervised medical service would be wasteful, enormous in amount and uncertain in efficiency, and

Whereas, such a panel system of socialized medicine is un-American in nature, in that it directly interferes with free enterprise, individual freedom, and free competition, therefore be it

Resolved, that we, the members of the Jefferson County Medical Society respectfully request that you use your full influence and vote in a determined effort to defeat S. B. 1606.

Your committee agrees with the conclusions of the petitioners, and recommends that our State Secretary be requested to address each member of both Houses of Congress with a statement of our objections to this vicious bill and our earnest request for their individual and collective efforts to secure its defeat.

Signed by the committee.

A. A. Ross, Chairman,
M. B. Stokes,
C. O. Terrell,
W. A. Davidson,
S. L. Witcher.

On motion of Dr. H. R. Dudgeon, seconded by Dr. Powell, the report was adopted.

Dr. W. A. Lee, Chairman of the Reference Committee on Finance, then presented the report of the Reference Committee on Finance, as follows:

Report of the Reference Committee on Finance

We beg to report on the following committee reports handed to us for consideration: Treasurer's Report; Board of Trustees Report, including Auditor's Report, except that part referring to the Public Relations Committee and that part referring to amendments to the Constitution and By-Laws; Report of Committee on Library Endowment.

We have studied these reports in detail, and find them complete and correct.

Our committee endorses and recommends their adoption as read before this body.

W. A. Lee, Chairman,
J. M. Travis,
A. C. Traweek,
G. A. L. Kusch,
R. G. Johnson.

On motion of Dr. Lee, seconded by Dr. Nash, the report was adopted.

Dr. H. R. Dudgeon, Chairman of the Reference Committee on Amendments to the Constitution and By-Laws, then presented the report of the committee, as follows:

Report of Reference Committee on Amendments to the Constitution and By-Laws

Dr. Dudgeon: We have a number of proposed amendments to the By-Laws.

AMENDMENTS TO CONSTITUTION AND BY-LAWS

The first is limiting years of service of members of the Board of Trustees:

Amend Section 1, Chapter III, of the By-Laws (page 12, January 1, 1945, edition) by adding thereto, in line 8 of the section following the words "each year," the following sentence: "No trustee shall serve as such for more than two terms of five years each."

Dr. Dudgeon moved the adoption of the proposed amendment. The motion was seconded by Dr. Ross, and carried.

Limiting years of service of councilors:

Amend Section 1, Chapter IV, of the By-Laws (page 13, January 1, 1945, edition) by adding to line 6 of the section, following the word "year," the following sentence: "No councilor shall serve as such for more than three terms of three years each."

On motion of Dr. Dudgeon, seconded by Dr. Heare, the amendment was adopted.

Change in method of electing councilors:

Amend Section 1, Chapter IV, of the By-Laws (page 13, January 1, 1945, edition) by adding to the section the following sentence: "Election of councilors shall be upon nominations made by district societies, at their regular meetings, or in the instance no such society exists or is in a position to so nominate, by a majority vote of the elected delegates of county societies from the district concerned."

On motion of Dr. Dudgeon, seconded by Dr. Powell, the amendment was adopted.

Limiting the term of service of members of the Council on Medical Defense:

Amend Section 1, Chapter V, of the By-Laws (page 15, January 1, 1945, edition) by adding to line 5 of the section, following the word "year," the following sentence: "No member of this Council shall serve as such for more than two terms of four years each."

On motion of Dr. Dudgeon, seconded by Dr. Shannon, the amendment was adopted.

The next refers to the Council on Scientific Work:

Amend Section 5 (a-2) of Chapter IX, of the By-Laws (page 20, January 1, 1945, edition) by adding to line 6 of the section, following the word "office," the following sentence: "No member of this Council shall serve as such for more than two terms of five years each."

On motion of Dr. Dudgeon, seconded by Dr. A. C. Scott, the amendment was adopted.

The next refers to the Council on Medical Economics:

Amend Section 6 (a-3), of Chapter IX, of the By-Laws (page 21, January 1, 1945, edition) by adding to line 2 of the page, following the word "office," the following sentence: "No member of this Council shall serve as such for more than two terms of five years each."

On motion of Dr. Dudgeon, seconded by Dr. Schenewerk, the amendment was adopted.

The next refers to the Council on Postgraduate Medical Education:

Amend Section 7 (a-4), of Chapter IX of the By-Laws (page 21, January 1, 1945, edition) by adding to line 6 of the section, following the word "office," the following sentence: "No member of this Council shall serve as such for more than two terms of five years each."

On motion of Dr. Dudgeon, seconded by Dr. Shannon, of Dallas, the amendment was adopted.

This refers to the Committee on Legislation:

Amend Section 8 (a-5), Chapter IX of the By-Laws (page 21, January 1, 1945, edition) by adding to line 6 of the section following the word "office," the following sentence: "No member of this Committee shall serve as such for more than two terms of five years each."

On motion of Dr. Dudgeon, seconded by Dr. Schenewerk, the amendment was adopted.

This refers to the Committee on Public Relations:

Amend Section 9 (a-6), Chapter IX, of the By-Laws (page 22, January 1, 1945, edition) by adding to line 12 of the section, following the word "members," the following sentence: "No member of this Committee shall serve as such for more than two terms of five years each."

On motion of Dr. Dudgeon, seconded by Dr. Campbell, the amendment was adopted.

The next refers to the Committee on Health Problems in Education:

Amend Section 10 (a-7), Chapter IX, of the By-Laws (page 22, January 1, 1945, edition) by adding to line 7 of the section, following the word "office," the following sentence: "No member of this Committee shall serve as such for more than two terms of five years each."

On motion of Dr. Dudgeon, seconded by Dr. Schenewerk, the amendment was adopted.

Referring to the Committee on Collection and Preservation of Records:

Amend Section 11 (a-8), Chapter IX, of the By-Laws (page 23, January 1, 1945, edition) by adding to line 6 of the section, preceding the words "The Chairmanship," the following sentence: "No member of this Committee shall serve as such for more than two terms of five years each."

On motion of Dr. Dudgeon, seconded by Dr. Shannon, the amendment was adopted.

Referring to the Committee on Cancer:

Amend Section 12 (a-9), Chapter IX, of the By-Laws (page 23, January 1, 1945, edition) by adding to line 7 of the section, following the word "office," the following sentence: "No member of this Committee shall serve as such for more than two terms of five years each."

On motion of Dr. Dudgeon, seconded by Dr. Schenewerk, the amendment was adopted.

Referring to the Committee on Tuberculosis:

Amend Section 3 (a), Chapter IX, of the By-Laws (page 19, January 1, 1945, edition) by adding to line 9 of the section, between the word "Relations" and "(10)," the following phrase: "The Committee on Tuberculosis," renumbering the remaining phrases of the section accordingly.

On motion of Dr. Dudgeon, seconded by Dr. Shannon, the amendment was adopted.

And the following:

Amend Chapter IX of the By-Laws (page 23, January 1, 1945, edition) by adding a new section, Section 13, between the present Section 12 and Section 13, as follows, renumbering the subsequent sections of the chapter accordingly: "Section 13 (a-10) The Committee on Tuberculosis shall consist of five members. The members of the first committee shall be appointed for one, two, three, four, and five years, respectively, and thereafter the President-Elect shall appoint to fill vacancies created by expiration of term of office. The chairmanship of the committee shall be determined by the appointive authority when the term of office of the incumbent chairman expires, or the office for any reason becomes vacant. These appointments shall be confirmed by the House of Delegates, and shall be considered at the time of election of officers. No member of this committee shall serve as such for more than two terms of five years each. It shall be the duty of this committee to give continued study and consideration to the problem of tuberculosis in all of its phases, coöperate with the State Health Department and constituted health authorities throughout the state in the campaign of prevention and suppression of the disease, and promote and direct activities of the State Medical Association of Texas in this connection."

On motion of Dr. Dudgeon, seconded by Dr. Shannon, the amendment was adopted.

The following amendment to the Constitution was offered by Dr. A. C. Scott:

"Amend Section 1, Article IV, of the Constitution, by adding to the section on page 5 of the January 1, 1945, edition thereof, the following: 'It shall be within the authority and power of the Board of Trustees, and it shall be its duty, to assume control of the Association under any circumstances arising from war, or other contingencies beyond the control of the constituted authorities of the Association, and when acting in such capacity it shall have the authority to suspend the Constitution and By-Laws of the Association to the extent necessary and for the duration of the emergency only. When acting under such temporary authority, the Board shall have the right to inaugurate such procedures as will insure the perpetuation of the Association and the accomplishment of its objectives to the extent possible under the circumstances.'"

Your committee wonders who would determine the nature of the emergency necessitating the taking over of the control of the Association from its constituted authorities, the House of Delegates and its

elected officers. It further wonders who would determine when such an emergency ends. The amendment is not specific on those points. It presumes the House of Delegates is the only authority with power to turn the affairs of the Association over to any other body, and that it would be the only power capable of saying when such emergency is at an end. Your committee believes it would be unwise to attempt to curtail the authority of the House of Delegates in any way further than it is already limited by the Constitution and By-Laws.

We recommend that the amendment be rejected.

On motion of Dr. Dudgeon, seconded by Dr. Shannon, the report of the committee, rejecting the proposed amendment, was adopted.

The following amendment to the By-Laws was offered by Dr. A. C. Scott:

"Amend Section 3, Chapter II of the By-Laws (page 10, January 1, 1945, edition) by changing the period (.) in line 6 of the section following the word, "President-Elect" to a comma (,), and adding the following sentence: 'which shall be upon the last day of the annual session, or in the instance no annual session is held by that time, on the last day of the month of June. In the instance the President-Elect should of necessity succeed to the Presidency at such a time, it shall be the duty of the Chairman of the Board of Trustees of the Association to invest him with the office.'"

Failure to accept the preceding amendment (to the Constitution) kills this amendment, and we recommend that it also be rejected.

On motion of Dr. Dudgeon, seconded by Dr. Schulze, the report of the committee was adopted and the proposed amendment was rejected.

Dr. Dudgeon: On page 31 of the Handbook in the report of the Board of Trustees, we find the following:

"It is quite evident to all who have occasion to determine proper action of officers and groups comprising the State Medical Association, that there is need of a complete overhauling of both Constitution and By-Laws. The Board of Trustees therefore recommends that such revision be accomplished as expeditiously as possible, and that the President of the Association, the President-Elect, and the Board of Trustees be appointed to make such revision. Section 2, Article XV of the Constitution (page 7, January 1, 1941, edition), authorizes such revision upon a two-thirds majority vote of the House of Delegates at any annual session, provided notice that such revision will be made has been given at a preceding session, and that the proposed revision be published in the JOURNAL not later than approximately three months prior to the annual session in which the final vote thereon is to be taken. This recommendation, if approved by the House of Delegates, may be considered such a prior notice.

"It is the opinion of the Trustees that our Constitution and By-Laws should provide that no appointed or elected member of a council or committee of the Association shall serve in any given capacity for a period in excess of ten years.

"It is also the opinion of the Board of Trustees that the present Committee on Tuberculosis should be made a standing committee, with overlapping, five-year terms of office.

"The Trustees are further of the opinion that the By-Laws should be so amended as to require that Councilors be nominated in their respective Councilor Districts, under a suitable and consistent plan, with confirmation or election by the House of Delegates.

"The Board would also recommend that county medical society legislative committees be set up on an overlapping term of office basis, so that a continuing policy may be inaugurated and maintained. This is done now in county medical societies in the matter of boards of censors and delegates to the State Medical Association."

Your committee recommends the adoption of this portion of the report.

Dr. Dudgeon moved the adoption of the report and the motion was seconded by Dr. Knapp.

President-Elect Cody: My understanding is, from what has just been read, that the revision is to be accomplished during the term of 1947-1948. I am getting that very clear now so there will be no misunderstanding.

President Connally: It could come up at the first meeting of the House of Delegates at the next annual meeting, and it would have then been on the table a year.

The vote was taken and the recommendation of the committee was adopted.

Dr. Dudgeon: Now this is a portion of the report of the Committee on Library Endowment, page 82 of the Handbook:

"Amend Chapter 9, of the By-Laws, January, 1945, edition, by inserting the following matter between Sections 9 and 10 (page 22), renumbering all following sections accordingly:

"'Section 10. (a-7). The Committee on Library Endowment shall consist of five members. The members of the first committee shall be appointed for one, two, three, four, and five years, respectively, and thereafter the President-Elect shall appoint to fill vacancies created by expiration of term of office. The appointments shall be confirmed by the House of Delegates and shall be considered at the time of election of officers. The chairmanship of the committee shall be determined each year by the President-Elect when he assumes the office of President. It shall be the duty of this committee to secure donations and endowment funds for the Texas Memorial Medical Library Association, and to keep the membership of the Association acquainted with the services offered by the Library to members and the public, and its needs for continuous greater development and greater services. This committee shall present to each annual meeting of the House of Delegates a report covering its activities during the preceding year.'"

Your committee recommends the adoption of this portion of the report.

On motion of Dr. Dudgeon, seconded by Dr. Shearer, the recommendation of the committee was adopted.

Dr. Dudgeon then moved the adoption of the entire report, and the motion was seconded by Dr. Shannon.

Dr. Scott: Before the final adoption of this report as a whole, I would like to ask a question. The Constitution says that the House of Delegates may amend any Article of this Constitution by a two-third vote of the delegates registered, provided, and so forth. I do not think the amendments I presented are worth a fight, but I am wondering if our procedure is not incorrect. It seems to me, according to our Constitution, that anyone has a right to present an amendment to the organization in open session. Such amendment must then lie on the table for a year.

After considerable discussion, the vote was taken on the motion to adopt the report as a whole, and President Connally announced that Dr. Scott's proposed amendment to the Constitution will lie on the table for a year, and then be presented to the House of Delegates, together with the recommendation of

the Reference Committee on Amendments to the Constitution and By-Laws.

Respectfully submitted,

H. R. Dudgeon, Chairman,
A. R. Shearer,
Joe A. Shepperd.

Dr. T. M. Jarmon, Chairman of the Reference Committee on Scientific Work, then presented the report of the committee as follows:

Report of Reference Committee on Scientific Work

The following resolution pertaining to anesthesiology was introduced by Dr. Moore:

RESOLUTION ON ANESTHESIOLOGY

Whereas, anesthesiology is a recognized specialty in the practice of medicine, the same as surgery, internal medicine, roentgenology, and so forth, and

Whereas, anesthesiology has its own specialty board (No. 13) as recognized by the American Medical Association, and

Whereas, the Texas Association of Medical Anesthetists, the American Society of Anesthesiologists and the American Board of Anesthesiology, are vitally interested in the maintenance of the highest standards of education and practice of the physician anesthetist, and

Whereas, many hospitals and insurance plans now include anesthesia as a part of the hospitalization expense of the patient, not always making clear to the patient the exact status of the anesthesia as to whether all or part is paid by the insurance plan, and the patient thinks the doctor should not charge more, and

Whereas, the description of anesthesia is confusing in insurance plans and causes some discord between doctors, patients and insurance companies, therefore be it

Resolved, that the State Medical Association of Texas recognize anesthesiology as a separate medical specialty, the same as surgery, internal medicine, roentgenology, and so forth, and be it further

Resolved, that fees for professional anesthesia service not be stated or restricted in any way so as to limit the physician's prerogative of assessing a fee which he may deem adequate. If an insurance company wishes to set a maximum on any professional service payable under a given policy, it should be understood this is a policy limit payable to any qualified anesthesiologist, whether or not employed by the hospital, the sum of which may be applied towards a professional fee, and be it further

Resolved, that the State Medical Association of Texas recommend to Texas Hospitals, the Blue Cross Plan and any or all insurance plans approved by the State Medical Association, that anesthesiology be recognized as a medical specialty, in connection with hospital service along with the specialties of surgery, internal medicine and the like.

Our Committee wishes to make a distinction between licensed physicians and nurses, and technicians who have had training in anesthesiology. We do not approve of the recognition of technicians as specialists in anesthesiology.

On motion of Dr. Jarmon, seconded by Dr. Clarke, this recommendation of the committee was adopted.

We have read the report of the Council on Scientific Work, and approve the same in full.

On motion of Dr. Jarmon, seconded by Dr. Shearer, this part of the report was adopted.

We have read the report of the Committee on Tuberculosis, and especially wish to commend the committee for its recommendation of the establishment of regional sanatoria.

On motion of Dr. Jarmon, seconded by Dr. Travis, this portion of the report was approved.

We have read the report of the Committee on Venereal Diseases, and especially wish to emphasize the importance of the reference made to the lack of scientific proof of curability of syphilis by penicillin.

On motion of Dr. Jarmon, seconded by Dr. Hudgins, this portion of the report was adopted.

Dr. Jarmon: The report of the Committee on Malaria has been read and approved. We commend the committee on its efforts to familiarize the profession with the newer aspects of the malarial problem.

On motion of Dr. Jarmon, seconded by Dr. Shearer, this portion of the report was approved.

We approve the report of the Committee on Fractures.

On motion of Dr. Jarmon, seconded by Dr. Yeager, this portion of the report was approved.

The report of the Committee on Maternal and Child Health has been reviewed and endorsed, without reservation.

On motion of Dr. Jarmon, seconded by Dr. Godley, this portion of the report was approved.

This committee approves in principle the plans of the Cancer Committee to control cancer, and the proposed coöperation with the American Cancer Society. However, the manner of coöperation has not been made clear to this committee, either by the report of the Cancer Committee, by attendance on the meeting of the Cancer Committee on May 8, or by consultation with its individual members. The stated purposes of the alliance between the State Association and the American Cancer Society have been triple, namely, education, research, and service to the cancer patient. This committee recognizes the fact that the State Medical Association supports unreservedly both education of the public and cancer research. There is room for considerable doubt, however, as to the wisdom of a medical problem of the proportion of cancer being controlled by an organization composed in good part by laymen. This committee also feels that there should be a more complete definition of the method of operation of the proposed field service to cancer patients, which, from present information, could conflict with the principles and customs of organized medicine.

We recommend, therefore, that this field service be defined in such a manner as to be made more understandable to the members of the State Medical Association before the entire report of the Cancer Committee be adopted.

I move the adoption of that part of the report.

Dr. E. W. Bertner, of Houston: I will second the motion. However, I am sure the Reference Committee has not gone into the matter thoroughly. The plan was discussed this afternoon for two hours, and a large number of the members of this House were present, and I feel sure that they will indicate by the vote that they endorse the program wholeheartedly.

There is nothing in the program that is not controlled entirely by the State Medical Association, whether it be service, research, or education. The program is sound, and I assure you that the charter that was adopted for the Texas branch of the American Cancer Society is one of the outstanding charters of this country; and it was indicated by a representative of the American Cancer Society who was here today and told us that it was the most complete and most accurately developed charter that has ever been produced by the American Cancer Society, in which the medical societies, down to the county medical society, have full control of every activity.

As to the service program, it must first be approved by this House of Delegates, by the district society, and by the county society. Nothing can be done, even in the county, without approval of the county medical society.

Dr. Jarmon: Our committee has spent a substantial part of the day listening to various members of the Association. One complaint is that recently there was printed in one of the Houston papers, an interview given out by a layman, which proposed that ultimately they were going to have in every community a woman to each twenty-five families to serve as an educational committee in an advisory capacity.

We find substantial objection to the plan, and for that reason our committee has felt it advisable to present this matter in such a way that it can be understood by all.

Those of us who have been in medicine for a number of years and have had contacts with organizations of this kind, know that it is most difficult to control laymen. The purpose is wonderful, and as long as the medical profession can control it, it is fine, but when we employ lay people in organizations of this kind, it is most difficult to control them.

You can run into difficulty by turning over a substantial part of the workings of our organization to laymen who are going to be the contact people with out patients.

We are in favor of the cancer program. I think that this is probably the best plan that Dr. Bertner and his group can present, and whether or not the House wishes to adopt the plan is a matter for your consideration.

Dr. E. A. Rowley: I think I would be opposed as quickly as anyone to laymen having any control over this plan. I can see nothing at all in it that would give any layman control, in the county or the district or anywhere. It is entirely in the hands of the medical profession.

Vice-President Whigham: I believe the Reference Committee has misunderstood the intention of the Cancer Committee. The American Cancer Society is putting out a lot of literature. That has all been approved by a group of doctors. The literature is nothing in the world but education. It is a question of advertising the importance of the cancer problem to the public, and this information is put out by laymen. I think that is the only part the laymen play, and that is under the supervision and direction of the doctors. I think the best thing is to let it go as it is. It is enlightening the public.

Dr. A. C. Scott: I would like to offer a substitute for the Reference Committee's report. I move that the Cancer Committee's report be adopted in its entirety.

The substitute motion was seconded by Dr. W. D. Jones.

The vote was taken on the substitute motion and it prevailed.

On motion of Dr. Jarmon, seconded by Dr. John T. Moore, the report as a whole, as amended, was adopted.

Dr. George A. Schenewerk, of Dallas, then presented the report of the Reference Committee on Medical Service and Public Relations, as follows:

First Report of Reference Committee on Medical Service and Public Relations

Report of Board of Trustees: The committee approves the report of the Board of Trustees pertaining to the Public Relations Committee, and recommends the acceptance of the proposals of the Board for the continuation of this committee's work.

On motion of Dr. Schenewerk, seconded by Dr. Hudgins, that portion of the report was adopted.

Report of Council on Medical Defense: Dr. W. D. Jones has been Chairman of this Council since its inception, and it was with extreme regret that the House of Delegates heard him announce that he would, after this term, no longer carry this responsibility. We feel that the record will show that under the guidance of Dr. Jones throughout the years, the number of malpractice damage suits has been held to a minimum, and those which reached the stage of trial were handled to the best advantage.

We recommend the adoption of the report.

On motion of Dr. Schenewerk, seconded by Dr. Shearer, that portion of the report was adopted.

Report of Council on Medical Economics: We have given careful consideration to the report of the Council on Medical Economics.

The House of Delegates passed a resolution two years ago endorsing the principle of voluntary prepayment for hospital and medical service, and the Council on Medical Economics was instructed to bring in a report suggesting some general principles for the guidance of the House of Delegates in its dealings with the agencies which propose to provide such service. The Council has been guided very largely by the policies of the American Medical Association in making its reports.

The Council on Medical Economics has proposed some general standards which it recommends to be followed by insurance companies or other groups which offer such service to the public. These standards are intended to safeguard the interests of the public and of the medical profession.

It does not propose to endorse specifically any company plan or incorporation, but it does propose that the agencies which comply with the principles it has laid down be supplied with the stamp of approval of the State Medical Association. And it should adopt such oversight and restrictions as will fully safeguard the interests of the insured and of the medical profession.

On motion of Dr. Schenewerk, seconded by Dr. Nash, that portion of the report was adopted.

Report of Committee on Procurement and Assignment: We approve the very comprehensive report of this committee. In view of the many adverse circumstances under which this work was done, we can say, "Well done thou good and faithful servant."

On motion of Dr. Schenewerk, seconded by Dr. Jones, that portion of the report was adopted.

Report of Committee on Public Relations: It seems that the monkey has been placed squarely on the back of your Reference Committee. The report of the Committee on Public Relations is too diverse in its ramifications for us to cover it in full. We would especially commend the efforts of this committee to aid in the rehabilitation of returning medical men from the service.

No member of this reference committee claims to be expert in the matter of publicity, and any criticisms are not intended to be harsh or our suggestions dogmatic. We feel that the work done in regard to state legislative matters has been commendable, and the results satisfactory in the main. We would recommend a continuation of this service and an intensification of these efforts as may be demanded by the circumstances.

We are not quite so optimistic as to national affairs. It is our opinion that results are not being accomplished. We make this statement after hearing opinions expressed by many doctors over the state. We realize that these contacts may not be a proper cross section of opinion but it is the impression we have received. We also have noticed that the laity does not seem to have any better knowledge of the subject than formerly. This may be due to lack of proper activity on the part of the various individual doctors over the state. It is our under-

standing that the Public Relations Committee did not want its activity to be in the form of propaganda, and it may be right in this, but we do not see the success of the present program. We, therefore, suggest either abandonment of this part of the program or a revision of procedure.

It has always seemed improper and a hardship that the burden of expense should fall on the medical profession in its efforts to secure for the public the best in medical care, but since that has always been our policy, we would recommend that sufficient funds be provided this committee for the proper accomplishment of whatever program may be assigned to it.

On motion of Dr. Schenewerk, seconded by Dr. Ward, that portion of the report was adopted.

Report of Committee on Industrial Health: We approve this report, and compliment the committee on the good work it has apparently done. We recommend a continuation of its work in peacetime industry.

On motion of Dr. Schenewerk, seconded by Dr. Shearer, that portion of the report was adopted.

Report from Texas Hospital Association: We have given careful consideration to the address from the Texas Hospital Association, and we desire to commend and express appreciation for the interesting and informative material carried in the communication, believing such approaches to be of great value in cementing cordial relations between the two organizations. The report includes a statement, however, that "The Texas Association of Osteopathic Physicians and Surgeons has renewed the request initiated by them last year for a meeting with the committee of the Texas Hospital Association," together with a suggested agenda by the Osteopathic Association for consideration at such a meeting. The report further states that "The Board of Trustees of the Texas Hospital Association has authorized the President to appoint a committee to meet as requested, provided a similar committee is present from the State Medical Association of Texas." We, ourselves, have received no similar request from the Osteopathic Association. While we would not be discourteous to any group legally engaged in medical practice, your committee believes that the gap separating our body from the osteopathic physicians is too well known and fundamental to be narrowed by such a tripartite conference, and therefore we do not recommend appointment of a committee for the suggested purpose.

Motion was made by Dr. Schenewerk to adopt that portion of the report, and it was seconded by Dr. David.

Dr. Travis: Are the Texas hospitals or the osteopaths asking to meet with us?

President Connally: The facts are that they asked the hospitals for a conference and the hospitals agreed to give them a conference, provided we would have a committee from this Association present. The osteopaths have been after me all along to get that done. Dr. Reeves and I met with them at Waco, in November, and I told them I could not see anything to be gained by a conference, and that I was not going to ask our Executive Council or House of Delegates to appoint such a committee.

They had it all set to have this meeting in Dallas, and notified me they were going to have it, and I did not answer, and did not pay any attention to it. I could not see anything to be gained by it except a row.

Dr. J. H. Burleson: Let's get this thing absolutely straight this time. I don't want to go before the Legislature and go through any more things like I did before. Tell our Legislative Committee exactly what you want us to do with regard to the osteopaths. Let's don't have any more misunderstanding.

Dr. Bell: The statement the gentleman from the Hospital Association made the other day was simply a very nice way for the Hospital Association to keep from meeting with the osteopaths. They knew we were not going to appoint a committee to meet with the osteopaths.

Dr. Homan: We have no control over the accrediting of hospitals. That is done by the American Medical Association and the American College of Surgeons. Any action we take would not change in any way the accrediting of hospitals by either group.

Secretary Taylor: It occurs to me that the representative of the Hospital Association the other day sought our coöperation on not merely this one item, but in other matters. It seems to me that we should do something to assure the Hospital Association that we are willing to coöperate with them fully, and if we do, I believe we will avoid the contingency to which Dr. Burleson refers.

President Connally: I think we should have very close coöperation between this Association and the Hospital Association, without the assistance of the osteopaths.

Dr. Burleson: It seems to me we are in the same position we were in when fighting House Bill 314. What the Legislative Committee wants you to do, is to set up a definite program to be followed if any such legislation is introduced in the Legislature again.

Dr. Brindley: I think we ought to remember that neither the American College of Surgeons nor the American Medical Association would have anything to do with that law. It seems to me we ought to support the hospitals in opposition to any such measure.

Dr. Burleson: We have done that on three different occasions.

The vote was taken on the motion, and that portion of the report was adopted.

Respectfully submitted,

S. H. Watson, Chairman,
George A. Schenewerk,
S. D. Coleman,
Charles P. Yeager,
J. W. Ward.

Dr. C. E. Scull, of San Antonio, chairman of the Board of Councilors, then presented the report of the Board of Councilors as a reference committee.

Report of Board of Councilors as a Reference Committee

The Board of Councilors, met at the Hotel Galvez, May 7, 1946, with the following in attendance: Chairman, Dr. C. E. Scull; Secretary, Dr. R. T. Wilson; and Drs. E. A. Rowley, R. E. Windham, F. J. L. Blasingame, J. E. Clarke, A. E. Sweatland, G. V. Brindley, C. C. Nash, and W. E. Whigham.

The request of Bay City doctors for release from the Wharton-Jackson-Matagorda-Fort Bend Counties Medical Society was referred to Dr. Blasingame, councilor of the district, for further study and report to the Board.

Upon motion of Dr. Brindley, seconded by Dr. Rowley, unanimous permission was given the Fayette County Society and Colorado County Society, to form a new organization, to be called the Colorado-Fayette Counties Medical Society.

Dr. Nash, councilor of the Fourteenth District, stated that the Hunt-Rockwall-Rains Counties Medical Society had adopted a resolution to drop the names Rockwall and Rains Counties, and adopt the name of Hunt County Medical Society, since there is only one doctor in Rockwall County who paid dues last year, and one this year, and that there are no doctors in Rains County. Upon motion of Dr. Nash, seconded by Dr. Rowley, the resolution was unanimously approved.

The following nominations for Honorary Membership in the State Medical Association were approved:

Armstrong-Donley-Childress-Collingsworth-Hall Counties: Dr. Edgar W. Moss, Pharr.

Brazos-Robertson Counties: Dr. H. W. Cummings, Hearne.

Cameron-Willacy Counties: Dr. Benjamin L. Cole, Brownsville.

Dallas County: Drs. R. E. Beddoe, Galveston; W. A. Maupin, Rowlett; and W. W. Brandau, H. B. Decherd, W. E. Howard, R. R. Jackson, E. L. Jones, J. M. Martin, S. E. Milliken, W. F. Schmaltz, E. B. Strother, J. R. Sypert, and Rufus Whitis, all of Dallas.

Ector-Midland-Martin-Howard-Andrews-Glasscock Counties: Dr. G. S. True, Big Spring.

El Paso County: Drs. A. H. Butler, Brown W. Randel, and Samuel D. Swope, all of El Paso.

Falls County: Dr. S. S. Munger, Marlin.

Jefferson County: Dr. S. Ross Jones, Waco.

Milam County: Drs. Albert S. Epperson, Houston, and Isaac P. Sessions, Rockdale.

Nueces County: Dr. Alfred W. Davison, Corpus Christi.

Orange County: Drs. F. W. Lawson and C. E. Phillips, both of Orange.

Potter County: Dr. James B. Ozier, Amarillo.

Tarrant County: Dr. Fred A. Haggard, Fort Worth.

Taylor-Jones Counties: Drs. M. E. Campbell and Claude B. Leggett, both of Abilene.

Tom Green-Eight Counties: Dr. Walton W. Cobb, Fort Worth.

Respectfully submitted,

C. E. Scull, Chairman,
R. T. Wilson, Secretary.

On motion of Dr. Scull, seconded by Dr. Clarke, the report as a whole was adopted.

Dr. A. A. Ross, of Lockhart, Chairman of the Reference Committee on Resolutions and Memorials, then presented a further report of the Committee on Resolutions and Memorials, as follows:

Second Report of Reference Committee on Resolutions and Memorials

Our Committee approves the following resolution pertaining to the recognition of the work done by Dr. Roger Post Ames, and advises that the Secretary of the State Medical Association be directed to work out with Dr. W. M. Brumby, of Houston, who procured the introduction of the resolution, a feasible procedure in the premises:

RESOLUTION ON DR. ROGER POST AMES

Whereas, it was contended by the late Senator Morris Sheppard and Representative Ewing Thomason of Texas, that Dr. Roger Post Ames was entitled to representation on the Roll of Honor created by the Act of Congress, approved February 29, 1929, recognizing the high public service rendered by Major Walter Reed and those associated with him in the discovery of the cause and means of transmission of Yellow Fever, and

Whereas, Special Order No. 83, by General Fitzhugh Lee, Commanding Western District of Cuba, upon recommendation of Major Jefferson R. Kean, specifically transferred Dr. Roger Post Ames from the Regular Army, temporarily to Major Walter Reed's Commission, where he served until his work ended February 28, 1901, which order has only recently been located, therefore be it

Resolved, that it is the desire of the State Medical Association of Texas that the measure introduced by Senator Morris Sheppard in the 71st Congress, 3rd. Session (S. 1560) be re-introduced, and passed as written.

Respectfully submitted,

A. A. Ross, Chairman,
S. L. Witcher,
C. O. Terrell,
M. A. Davison.

On motion of Dr. Ross, seconded by Dr. John T. Moore, the report was adopted.

Dr. Marion M. Brown: There has been something said about keeping the record straight. May I rise to a point of order. There is a record that I want to keep straight. I heard the statement made tonight that Dr. Crowe had said there were pathologists practicing medicine in Texas without licenses. That will be looked into, and if it is found to be true, steps will be taken to see that it does not continue. (Applause.)

Dr. W. D. Jones introduced a resolution authorizing the Council on Medical Economics to carry out the provisions of the recommendation of the Executive Council in regard to Medical Prepayment Plans, and the resolution was referred to the Reference Committee on Medical Service and Public Relations.

On motion of Dr. Truman Terrell, seconded by Dr. H. E. Whigham, Dr. T. J. Crowe, Secretary, Texas State Board of Medical Examiners, was given the floor, in reference to the matter of pathologists practicing without license.

Dr. T. J. Crowe, of Dallas: If you will stop to think about the Medical Practice Act, you will realize that a pathologist does not have to have a license unless he treats. We have pathologists working as technicians in every hospital, and none of them, or very few of them, are licensed. In the future as in the past I am going to do my job according to law, and the best I know how.

Dr. Brown: Dr. Terrell made the statement that Dr. Crowe told him there were pathologists practicing in Texas and having no license. My opinion is that there is a whole lot of difference between a pathologist and a technician. I have always understood that a pathologist was a doctor and not a technician, and that is where I take exception. I do not think there is any reason for Dr. Crowe and me to argue on the floor of this House, but I am going to talk to Dr. Crowe as a member of the State Board of Medical Examiners.

On motion of Dr. Brindley, seconded by Dr. Parrish, the meeting adjourned until 8:00 a. m., Thursday, May 9, 1946.

THURSDAY, MAY 9, 1946

Minutes of the House of Delegates
Third Meeting

The House of Delegates was called to order by the President, Dr. H. F. Connally, at 8:30 a. m., Thursday, May 9, 1946, in the Basement Room, Hotel Galvez, Galveston, with an attendance of 108 delegates.

The Reference Committee on Credentials reported, as follows:

Fifth Report of Reference Committee on Credentials

Dr. Hall Shannon: There are 108 delegates present.

Secretary Taylor: That constitutes a quorum for the transaction of business.

Dr. A. A. Ross, Chairman of the Reference Committee on Resolutions and Memorials, then presented a further report of the Reference Committee on Resolutions and Memorials, as follows:

Third Report of Reference Committee on Resolutions and Memorials

Our State Association in its first meeting in several years, has been domiciled here on the Pirate Isle three and one-half days. We knew that war conditions would to some extent still prevail. Hence we were, and are, agreeably surprised that Galveston has been able to rise to the situation as well as she has. There has been a dearth of available rooms in the hotels, but the tourist courts and private homes have come to the rescue. Your committee believes that anyone sleeping out of doors has done so from choice, rather than from necessity.

The people down here are just folks—well, a little more, clever, fine folks, and we have enjoyed our stay and hope to come again before too long.

Nature has been kind, the sun overhead shines much like it does upstate but the Gulf breezes rob its rays of much of their power to distress. Not a tidal wave has been observed; the sea lions maintain a reasonable distance in the offing, and the mermaids throng the shoreline along the sea wall as of yore, when our boys were here in medical school.

Incidentally, some of said mermaids moved inland with some of said medical students years ago and the distinguished sons of some of these unions are here on our programs.

All in all, we approve Galveston and acknowledge the Island as part of Texas, and her medical school as a distinguished part of our educational system. In time we hope to fill in the lagoons, abolish the causeway, and join Houston as a suburb. Then we will have clinical material in abundance. Everything else seems adequate.

Finally, your committee resolves that the grateful appreciation of the State Medical Association be extended to Galveston, the Galveston County Medical Society, and all its members for their untiring efforts under great difficulty to meet the situation presented by this meeting. Her denizens have been gracious, courteous, and kind. We will take to our homes cheerful memories of our stay that will abide through the years.

On motion of Dr. Ross, seconded by Dr. Sweatland, the resolution was unanimously adopted.

Dr. L. B. Jackson, of San Antonio, Chairman of the Reference Committee on Reports of Officers and Committees, then presented a further report of the committee, as follows:

Second Report of Reference Committee on Reports of Officers and Committees

The following resolution was introduced by the Chairman of the Section on Clinical Pathology:

RESOLUTION ON PATHOLOGY IN THE PRACTICE OF MEDICINE

The State Board of Medical Examiners has ruled that pathology is not the practice of medicine and that a license to practice medicine is not required in order to practice pathology.

The Section on Clinical Pathology wants to call this matter to the attention of the House of Delegates. This Section desires the House of Delegates to recommend that the Medical Practice Act be so changed and amended that a license to practice medicine would be required for anyone practicing pathology and other diagnostic specialties.

The Committee recognizes the desirability and necessity of having all laboratories under the direct supervision and control of licensed physicians. We therefore recommend that the Medical Practice Act be so changed or amended, as to require all laboratories to operate under the supervision of licensed physicians, in order that the work of technicians employed in said laboratories may be professionally checked.

On motion of Dr. Jackson, seconded by Dr. Reeves, that portion of the report was adopted.

The following resolution was presented by Dr. Robert E. Parrish:

RESOLUTION ON MEDICAL CARE OF FEDERAL CIVIL SERVICE EMPLOYEES

Whereas, under the present laws regulating the care and compensation of federal government civil service employees in case of injury in line of duty, an injured employee must choose one of a few specially appointed physicians and be treated in certain designated hospitals, therefore be it

Resolved, that the State Medical Association of Texas direct its Delegates to the American Medical Association to cause the American Medical Association to use its influence in Congress to change these laws, so that injured employees may choose any ethical, recognized physician, and any recognized hospital available to them for treatment, and that compensation be provided for both the physicians and the hospitals thus chosen.

The conditions set forth in this resolution are an encroachment on the liberty and relationship between doctor and patient, and should not be allowed to continue. We therefore recommend the adoption of the resolution.

On motion of Dr. Jackson, seconded by Dr. Shannon, this portion of the report was adopted.

President's Message.—

Dr. Jackson: After carefully reading the President's address, we hereby endorse it down to the portion recommending that no one past the age of 65 shall be eligible to hold elective office. We feel that it would be a great injustice to our Association to adopt this recommendation, and would suggest this should not be adopted. We feel that some of the most valuable members of our organization are past that age, and have rendered, are rendering, and will continue to render invaluable service both in and out of office if given an opportunity.

We further recommend that that portion of the address pertaining to changes in the Medical Practice Act and Basic Science Law be referred to our Legislative Committee for its consideration and disposal.

We wish to commend our retiring President for a very able administration of the affairs of the Association during his tenure of office under very trying circumstances. The medical profession of Texas has been most fortunate in having had so fearless and capable a leader as Dr. Connally during the trying years just past.

Dr. Jackson moved the adoption of the report, and the motion was seconded by Dr. Powell.

President Connally: I want to say a few words on that motion. In other words, I want to give my reasons, particularly for the suggested changes in the Texas Medical Practice Act.

So far as the age limit is concerned, that is all right. My reason for making that recommendation was to put these men to work earlier in the Association and to make room for the younger men who are coming on. I do not care anything about that part.

I made my recommendations according to my judgment as to what was for the best interests of this state. I made my recommendations based on fifteen years of experience gained from my service on the State Board of Medical Examiners, and I am fairly familiar with the working conditions in practically all the states of the union, and I think we need a basic science board.

The board I have recommended is exactly the same as the one the Public Relations Committee has been discussing with you all over the state, with this one exception, that in their proposal there is no provision made for a single doctor on that board; and if we embrace the basic science subjects, we are going to have two.

None of the teachers in the academic schools knows how to teach Pathology or Anatomy. They do not know anything about the application of their subject to the practice of medicine.

Another thing is, when you put full licensing power of all the doctors in Texas in the hands of a group of socialists—and I say that advisedly; not one time have you heard a Ph. D. who is not a doctor of medicine open his mouth against the Wagner-Murray-Dingell bills—you are going to get into trouble further down the line.

I admit that some of these basic science states, less than half a dozen of them, are working fairly well, but in Michigan last year they flunked one hundred and two A grade students, out of A grade medical schools.

The Michigan board and the Minnesota board will not reciprocate with each other. Oklahoma and Arkansas will not reciprocate with each other. There is more dissatisfaction between basic science boards than between other boards, and there is confusion everywhere.

I am advocating a basic science board, but I want two doctors on it who will coördinate the efforts of the board in the interests of the medical profession; and also because they are capable of teaching those two subjects. They are certainly as capable of giving intelligent examinations as are teachers out of A. & M., Baylor, T. C. U., and these other schools. I think I know a little about Baylor University. I am not as familiar with the other schools as I am there.

I am saying that because I believe it, and I am putting this out here because I think it is for the best interests of the State Medical Association for us to hold our basic science board in some degree under the control of medical ideas.

So far as the balance of it is concerned, I do not care anything about it. I do think when we turn these osteopaths loose we will be in worse shape than when we have them under our thumb.

There is going to have to be some change made before long. I am never going to support a measure or law to put the licensing of this group of doctors in Texas in the hands of a bunch of laymen. I am firmly of that conviction, and I think I know more about it than the majority of you fellows know.

We are going to have to present a solid front in Austin, and we will have a much better chance to fit our plans into the wishes of the Legislature if we present a united front than if we are divided. We are going to have a hard time overcoming the influence that has been gained there by the cults, and if we do not fix our measure right we are not going to get it through there.

There is going to be some opposition to it. There is not a man in the Legislature who knows me, who thinks I am in favor of that sort of a board, and if I go to him now and tell him I have changed my mind, I will not have much influence with him, and I never was able to support a false position. I have never lied to you fellows, unless I have done it through ignorance, and I am not going to lie to them, because I do not believe that way, and I am not one who can change his mind over night, if it is something I am as familiar with as I am with this.

That part of my recommendation I would surely like to see you support. (Applause.)

Dr. Jackson: This matter was referred to our committee at about 11:00 o'clock last night. There is no question of the confidence reposed in Dr. Connally's ability, no question as to his experience, no question as to his honesty and sincerity of purpose. But at 11:00 o'clock last night we were not prepared to go into the question of the relationship of his recommendations to those that had been adopted by the House of Delegates by endorsing the report of the Legislative Committee and their recommendation of a basic science law.

We had adopted a resolution by Dr. Blasingame advocating the same basic science law. We did that just yesterday. We were uncertain, I personally was very uncertain, as to whether these two recommendations, or three recommendations, would coincide. We knew of no better procedure, at 11:00 o'clock last night, than to refer the matter to the Legislative Committee for consideration and disposal, so that they might harmonize all these recommendations and decisions. We are not having any fuss with Dr. Connally; we are not undertaking to differ with him, because we have not had an opportunity as a committee to study the matter.

(Secretary's Note: Then followed an extended debate in which the following members of the House of Delegates participated: Drs. John T. Moore, President Connally, J. H. Burleson, F. J. L. Blasingame, L. B. Jackson, Secretary Taylor, E. A. Rowley, L. H. Reeves, L. C. Powell, W. A. King, R. E. Windham, D. R. Knapp, R. H. Bell, J. C. Nichols, L. C. Heare, President-Elect Cody, Sam E. Thompson, S. H. Watson, A. C. Scott, C. O. Terrell, W. B. Russ, R. H. Niehuss, and E. W. Bertner.

The debate covers twenty manuscript pages in the report of the meeting. It is deemed sufficient to publish here the decision following the debate, and omit the verbatim discussion involved. The verbatim report of the discussion will be available to any member of the Association for inspection, study, or abstraction, upon application to the State Secretary. Numerous points of order and questions were raised, and all were decided with apparent satisfaction to the members engaged in the debate. The debate itself was harmonious, and the effort was clearly to accomplish results with as little parliamentary entanglement as possible. The Chairman of the Reference Committee having the matter in hand, Dr. Jackson, made it clear that the effort of the Committee was to harmonize the recommendations pertaining to legislation made by President Dr. Connally, with the report of the Legislative Committee, and Dr. F. J. L. Blasingame's resolution, and particularly that the committee had no intention of criticizing or antagonizing the views of Dr. Connally in the matter. The Chairman of the Legislative Committee insisted throughout that whatever decision was reached, it be in the form of a mandate; that nothing as to policy be left to the decision of the Legislative Committee. The suggestion was made that the effort to harmonize the three discussions mentioned here be left to the Executive Council, but the suggestion was abandoned when it was pointed out that the Executive Council itself is not authorized to set up policies for the Association. The proceedings at the time of the vote on the recommendation of President Connally, follow.)

Dr. L. B. Jackson: My motion was that whatever differences exist between the recommendation of the Legislative Committee, which has been reported favorably by this Reference Committee to this House of Delegates, and Dr. Blasingame's resolution; whatever differences exist between those and Dr. Connally's recommendation be harmonized. In other words, we would accept Dr. Connally's recommendation as a supplement to what we have already

adopted in this House of Delegates. (Applause.) When you vote for this motion, you vote for Dr. Connally's recommendation.

President-Elect Cody: As I understand the position of Dr. Connally, so long as there are two doctors of medicine on the proposed basic science board, his recommendation will be met.

President Connally: That is correct.

Dr. Sam E. Thompson: This whole discussion should be settled in two minutes. Shall we or shall we not have two doctors on the basic science board? Dr. Blasingame does not object to it. Dr. Jackson does not object to it. It seems to me that is about all there is to it.

The vote was taken on the motion of Dr. Jackson, and the motion was lost.

On motion of Dr. H. H. Niehuss, seconded by Dr. Moore, the vote was made unanimous.

Dr. Jackson: We wish to commend our retiring President for a very able administration of the affairs of the State Medical Association during his tenure of office under very trying circumstances. The medical profession of Texas has been most fortunate in having had such a fearless and capable leader as Dr. Connally during the trying years just past.

On motion of Dr. Jackson, seconded by Dr. Shearer, that portion of the report was adopted.

On motion of Dr. Jackson, seconded by Dr. Schenewerk, the report as a whole, as amended, was adopted.

Dr. S. H. Watson, Chairman of the Reference Committee on Medical Service and Public Relations, then presented further report of the Committee on Medical Service and Public Relations, as follows:

Second Report of Reference Committee on Medical Service and Public Relations

We recommend the adoption of the following resolution, introduced by Dr. W. D. Jones:

Resolved, that the council on Medical Economics be, and is hereby authorized immediately to carry out the provisions of the recommendations of the Executive Council in regard to Medical Prepayment Plans, including the designation of an adjudication committee and the nominees for the board of directors of the Group Medical and Surgical Service.

Respectfully submitted.

S. H. Watson, Chairman,
George A. Schenewerk,
S. D. Coleman,
Charles P. Yeager,
J. W. Ward.

On motion of Dr. Watson, seconded by Dr. Travis, the report was adopted.

Election of Officers

President Connally: Next in order will be the election of officers. The appointed tellers are Drs. George A. Schenewerk, J. D. Nichols, S. C. Richardson, and E. D. Dumas.

Upon nomination, the following officers, council, and committee members were elected:

PRESIDENT-ELECT

Dr. B. E. Pickett, Sr., Carrizo Springs.

VICE-PRESIDENTS

Dr. S. D. Whitten, Greenville.
Dr. C. P. Yeager, Corpus Christi.
Dr. J. M. Campbell, Goldthwaite.

TRUSTEES

Dr. T. C. Terrell, Fort Worth.

COUNCILORS

First District, Dr. Ralph H. Homan, El Paso.
Fourth District, Dr. O. N. Mayo, Brownwood.
Eleventh District, Dr. J. M. Travis, Jacksonville.
Thirteenth District, Dr. R. G. Baker, Fort Worth.
Fourteenth District, Dr. C. C. Nash, Dallas.

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Dr. Holman Taylor, Fort Worth.
Dr. F. J. L. Blasingame, Wharton.

ALTERNATE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Dr. R. B. Anderson, Fort Worth.
Dr. L. H. Reeves, Fort Worth.

MEMBER COUNCIL ON MEDICAL DEFENSE

Dr. L. B. Jackson, San Antonio.

MEMBER COUNCIL ON SCIENTIFIC WORK

Dr. Joseph B. Copeland, San Antonio.

MEMBER COMMITTEE ON MEDICAL ECONOMICS

Dr. Tom B. Bond, Fort Worth.

MEMBER COMMITTEE ON LEGISLATION

Dr. L. H. Reeves, Fort Worth.

MEMBER COMMITTEE ON COLLECTION AND PRESERVATION OF RECORDS

Dr. E. W. Bertner, Houston.

MEMBER COMMITTEE ON HEALTH PROBLEMS IN EDUCATION

Dr. Sam N. Key, Austin.

MEMBER COMMITTEE ON CANCER

Dr. David A. Todd, San Antonio.

MEMBER COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION

Dr. David W. Carter, Jr., Dallas.

Expression of Sympathy

Dr. Wilson David: As all of you probably know, the mother of Dr. Titus Harris died yesterday. I offer a motion that our Secretary be instructed to get in contact with Dr. Harris and express to him and his family our sincere sympathy and condolence.

The motion was seconded by Dr. Hall Shannon, and unanimously prevailed.

Upon motion of Dr. J. D. Nichols, seconded by Dr. A. R. Shearer, the meeting of the House of Delegates of the State Medical Association of Texas adjourned *sine die*.

Combined Section Meeting

The Combined Sections Meeting was called to order by the President, Dr. H. F. Connally, at 2:15 p. m., May 9, 1946, in the Ballroom, Hotel Galvez, at Galveston.

Dr. M. Herbert Barker, Chicago, discussed the subject of "Nitrogen and Phosphorus in the Treatment of Renal Disease."

Dr. O. Theron Clagett, Rochester, Minn., discussed the subject, "Surgery in the Aged."

Dr. C. C. Cody, President-Elect, then assumed the chair.

Dr. Nicholson J. Eastman, Baltimore, Md., discussed the subject, "Penicillin in Obstetrics."

Dr. Jack S. Guyton, Baltimore, Md., discussed the subject, "The Relationship of Ophthalmology to General Medicine."

Dr. Wiley D. Forbus, Durham, N. C., discussed the subject, "Brucellosis, a General Pathological Consideration of Human and Animal Infection by Brucella."

Dr. James L. Wilson, Ann Arbor, Mich., discussed the subject, "The Influence of Maternal Health on the Occurrence of Congenital Anomalies."

President-Elect Cody: The State Medical Association wishes to take this occasion to thank the distinguished visitors who have participated in our program. Particularly do we wish to thank those who have put on the program this afternoon.

To our own members who have participated in the program and have made this meeting such a success, we likewise feel grateful.

Allow me to take this occasion to express again to you my thanks and gratitude for the high honor you have conferred on me. It is deeply appreciated.

The whole world is out of joint. It is to be expected that this next year will be a difficult year of readjustment and of reconversion.

The State Medical Association is a rather complex and intricate mechanism in which a large number of men have a most important part. It is necessary for the whole organization to function with superior efficiency during the next year, in order that we may meet again at Dallas a year from now with the consciousness that much has been accomplished.

The Seventy-Ninth Annual Session of the State Medical Association of Texas is adjourned herewith, *sine die.*

MEDICAL OFFICERS RETURNING TO TEXAS*

(Corrections: Ralph C. Crawford, formerly of Houston, has returned to Longview; James P. Gill, formerly Corpus Christi, to San Antonio; John F. Halamicek, formerly Houston, to El Campo; George S. Littell, formerly Dallas, to Plainview; Edwin E. Middleton, formerly Abilene, to Ann Arbor, Mich.; Francis A. Mood, formerly Nocona, to McKinney; John C. Powell, Jr., formerly San Antonio, to Fort Worth; Ivan H. Readinger, formerly El Paso, to Fort Worth; and Cecil G. Yarbrough, formerly Midland and Denton, to Coleman.)

NAME	Serv.†	Location	Release Date
Bell County			
12. Wells, Benjamin B.	A	Temple	
Bexar County			
93. Altgelt, Daniel D.	A	San Antonio	Jan., 1946
94. Gonzalez, Hesiquio N.	A	San Antonio	
95. Partain, Jack M.	A	San Antonio	
96. Urrutia, Adolfo	A	San Antonio	
Brooks-Duval-Jim Wells Counties			
8. Garcia, Robert E.	A	Falfurrias	
Clay-Montague-Wise Counties			
2. Compere, Clinton L.	A	Decatur	
Comal County			
3. Schaefer, John K.	A	New Braunfels[1]	Apr., 1946
Dallas County			
139. Ault, Charles A., Jr.	A	Dallas	
140. De Haro, Joseph A.	A	Dallas	
141. Donoho, Charles P.	A	Dallas	
142. Henderson, Walter T., Jr.	A	Dallas	
143. Hurt, Leonard B.	A	Dallas	
144. Miller, J. E.	A	Dallas[2]	Mar., 1946
145. Mitchell, Harry J., Jr.	A	Dallas	Dec., 1945
146. Weekley, F. Clay	A	Dallas	
Ector-Midland-Martin-Howard-Andrews-Glasscock Counties			
9. Thornton, E. H.	A	Odessa	
El Paso County			
40. Stevenson, Walter H.	A	El Paso	
Galveston County			
41. Marsh, George	N	Texas City	
Harris County			
190. Brown, James A.	N	Houston	June, 1946
191. Cody, Melville L.		Houston	
192. Davenport, Harbert, Jr.	A	Houston[3]	Apr., 1946
193. Gardner, Irvin B.	A	Houston	
194. Kilgore, N. A.	A	Houston	July, 1946
195. McKinney, W. W.	A	Houston	
196. Mangum, H. J.	A	Houston	
197. Meynier, M. J.		Houston	Apr., 1946
198. Moody, Irvin W.		Houston	
199. Petway, M. E.	A	Houston	
Harris County—Continued			
200. Salerno, Joseph P.	A	Houston	
201. Tucker, J. Norris	A	Houston	Apr., 1946
202. Ulert, I. Alan	A	Houston	Jan., 1946
Kerr-Kendall-Gillespie-Bandera Counties			
7. Kern, J. C.	A	Kerrville[1]	
Kimble-Mason-Menard-McCulloch Counties			
4. Wright, Carleton C.	A	Junction	
Lubbock-Crosby Counties			
16. Parks, W. S., Jr.	A	Slaton[2]	Jan., 1846
McLennan County			
26. Goddard, C. G.	A	Waco	
27. Richey, Harvey M., Jr.	A	Waco	
Medina-Uvalde-Maverick-Val Verde-Edwards-Real-Kinney-Terrell-Zavala Counties			
5. Eads, Ray A.	A	Uvalde	
Palo Pinto-Parker Counties			
9. Bruce, Robert G.	A	Mineral Wells	
Pecos-Jeff Davis-Presidio-Brewster Counties			
3. Hill, Malone V.	N	Alpine	June, 1946
4. Robertson, A. H.	A	Iraan[3]	
Potter County			
21. Black, R. P.	N	Amarillo	Mar., 1946
22. Dine, William C.		Amarillo	
San Patricio-Aransas-Refugio Counties			
7. Zarsky, Emil P.	A	Refugio	
Tarrant County			
67. Austin, Carl M.	A	Fort Worth	
68. Funk, T. H.	A	Fort Worth	May, 1946
69. Hook, J. H.		Fort Worth	
Taylor-Jones Counties			
17. Cockerell, Earl R.	A	Abilene	Apr., 1946
Tom Green-Coke-Crockett-Concho-Irion-Sterling-Sutton-Schleicher Counties			
11. Kunath, Carl A.	A	San Angelo	Apr., 1946
Travis County			
29. Carter, Rexford G.	A	Austin[4]	Feb., 1946
30. Kreisle, James E.	A	Austin	
31. Speck, Carlos D., Jr.	A	Austin	
32. Wilson, James D.	A	Austin[5]	
Van Zandt County			
2. Cooper, Arlin B.	A	Ben Wheeler	
Washington County			
2. Hodde, Hermon O.	A	Brenham	Mar., 1946
3. Steinback, Herbert L.	N	Brenham	
Webb-Zapata-Jim Hogg Counties			
8. Montalvo, Lauro	A	Zapata	
Wharton-Jackson-Matagorda-Fort Bend Counties			
6. Simons, Jack H.	A	Newgulf	
7. Wagner, Robert G.	A	Wharton[6]	Dec., 1945
8. Yelderman, Gus C.	A	Rosenberg	
Wichita County			
15. Hay, Bruce		Wichita Falls[6]	
16. Wilson, Claude D.	A	Wichita Falls[7]	Mar., 1946

EDITOR'S NOTE: This list is the eighth of a series in which it is hoped to name all those physicians who have been in the Armed Forces during the war just passed and have now returned to Texas to resume civilian practice. The information in this list has been assembled from a variety of sources. While an attempt has been made to secure as complete and as accurate data as possible, we are aware that omissions and errors have been made. Not only for publication in the JOURNAL but also for the permanent records in the central office of the State Medical Association, we invite and urge correction of and addition to the material here submitted. Note that physicians from each county area are numbered consecutively following those listed in the May JOURNAL; the last number in each section therefore indicates the total physicians returned to that county area. The complete total for Texas named to date (May 25), including the accompanying list, is 1,217.

†A=Army; N=Navy; U=U. S. Public Health Service.

[1]Formerly of Houston.
[2]Formerly of San Antonio.
[3]Formerly of Jacksonville.

[1]Formerly of Sanderson.
[2]Formerly of Breckenridge.
[3]Formerly of Miles.
[4]Formerly of Houston.
[5]Formerly of Lubbock .
[6]Formerly of Austin.
[7]Formerly of Temple.

MISCELLANEOUS

COMING MEETINGS AND CLINICS

State Medical Association of Texas, Dallas, May 5-8, 1947. Dr. C. C. Cody, Jr., Houston, President; Dr. Holman Taylor, 1404 W. El Paso St., Fort Worth 3, Secretary.

American Medical Association, San Francisco, July 1-5, 1946. Dr. Roger I. Lee, Boston, President; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secretary.

Southern Medical Association, Miami, Fla., November 4-7, 1946. Dr. M. Y. Dabney, Birmingham, Ala., President; C. P. Loranz, Empire Building, Birmingham, Ala., Secretary-Manager.

Southwest Allergy Forum, Shreveport, La., April, 1947. Dr. W. H. Browning, Shreveport, La., President; Dr. Sim Hulsey, Medical Arts Bldg., Fort Worth, Secretary.

Texas Association of Medical Anesthetists, Dallas, May, 1947. Dr. Claudia Potter, Temple, President; Dr. Russell Bonham, Box 6237, Houston, Secretary.

Texas Association of Obstetricians and Gynecologists, Galveston. Dr. Allen McMurrey, Houston, President; Dr. Julius McIver, 714 Medical Arts Building, Dallas, Secretary.

Texas Chapter, American College of Chest Physicians. Dr. R. G. McCorkle, San Antonio, President; Dr. Elliott Mendenhall, 1217 Medical Arts Bldg., Dallas, Secretary.

Texas Club of Internists. Dr. Robert M. Barton, Dallas, President; Dr. Julian C. Barton, 414 Navarro St., San Antonio, Secretary.

Texas Hospital Association, Houston, March 27-29, 1947. Tol Terrell, Harris Memorial Methodist Hospital, Fort Worth, President; Mrs. Ruth Barnhart, 5709 Velasco, Dallas, Secretary.

Texas Neuropsychiatric Association, Dallas, May, 1947. Dr. Fred T. Rogers, Dallas, President; Dr. David Wade, 604 Capital National Bank Bldg., Austin, Secretary.

Texas Ophthalmological and Otolaryngological Society, Dallas, December, 1946. Dr. C. B. Williams, Mineral Wells, President; Dr. E. D. Dumas, 425 Medical Arts Bldg., San Antonio, Secretary.

Texas Orthopedic Society. Dr. E. A. Cayo, San Antonio, President; Dr. Edward Smith, 1215 Walker Ave., Houston, Secretary.

Texas Pediatric Society, Fort Worth, October, 1946. Dr. Max Woodward, Sherman, President; Dr. John E. Ashby, 3610 Fairmount, Dallas, Secretary.

Texas Public Health Association, Dallas. Dr. L. P. Walter, Austin, President; Mr. Earle W. Sudderth, Dallas County Health Department, Court House, Dallas, Secretary.

Texas Radiological Society, January, 1947. Dr. Herman Klapproth, Sherman, President; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secretary.

Texas Railway and Traumatic Surgical Association. Dr. F. L. Snyder, Fort Worth, President; Dr. Ross Trigg, First National Bank Bldg., Fort Worth, Secretary.

Texas Society for Mental Hygiene. Dr. Jack R. Ewalt, University of Texas Medical Branch, Galveston, President; Mrs. Elizabeth F. Gardner, 1617 Watchhill Road, Austin 21, Executive Secretary.

Texas Society of Gastro-Enterologists and Proctologists, Dallas, May, 1947. Dr. Tom E. Smith, Dallas, President; Dr. D. L. Curb, 704 Dallas Ave., Houston, Secretary.

Texas Society of Pathologists, Houston, January, 1947. Dr. May Owen, Fort Worth, President; Dr. C. T. Ashworth, Southwestern Medical College, Dallas, Secretary.

Texas State Heart Association, Dallas, May, 1947. Dr. Robert M. Barton, Dallas, President; Dr. M. B. Whitten, Medical Arts Bldg., Dallas, Secretary.

Texas Surgical Society, Houston, October 7-8, 1946. Dr. G. V. Brindley, Temple, President; Dr. Walter Stuck, 1426 Nix Professional Building, San Antonio, Secretary.

Texas Tuberculosis Association, Houston, September 16-17, 1946. Dr. J. B. White, Amarillo, President; Miss Pansy Nichols, 700 Brazos, Austin, Executive Secretary.

Third Panhandle, District Medical Society, Lubbock, October 8-9, 1946. Dr. W. A. Carroll, Claude, President; Dr. George Powers, Fisk Bldg., Amarillo, Secretary.

Fourth District Medical Society, Brady, November, 1946. Dr. H. L. Locker, Brownwood, President; Dr. Glenn H. Ricks, Brady, Secretary.

Seventh, Austin, District Society, Austin, July, 1946. Dr. Robert B. Morrison, Austin, President; Dr. M. I. Brown, Capital National Bank Bldg., Austin, Secretary.

Eighth, Ninth and Tenth Districts Medical Society, Orange, April, 1947. Dr. Walter F. Hasskarl, Brenham, President; Dr. George W. Waldron, Medical Arts Bldg., Houston, Secretary.

Eleventh District Society, Palestine, October, 1946. Dr. L. L. Travis, Jacksonville, President; Dr. C. B. Young, 929 S. Confederate, Tyler, Secretary.

Twelfth, Central Texas District Society, Corsicana, July 9, 1946. Dr. Thomas G. Glass, Marlin, President; Dr. H. F. Connally, Jr., Amicable Bldg., Waco, Secretary.

Thirteenth, Northwest District Society. Dr. A. L. Roberts, Fort Worth President; Dr. Joe R. Wise, 1212 W. Lancaster, Fort Worth, Secretary.

Fourteenth District Society, Gainesville, June 11, 1946. Dr. C. B. Thayer, Gainesville, President; Dr. V. L. Tuck, Sherman, Secretary.

Fifteenth, Northeast Texas, District Society, October, 1946. Dr. Frank Littlejohn Marshall, President; Dr. Henry H. Neihuss, Greggton, Secretary.

CLINICS

Dallas Southern Clinical Conference, Dallas, March 17-20, 1947. Miss Thelma J. Webb, 1133 Medical Arts Bldg., Dallas 1, Executive Secretary.

Post Graduate Medical Assembly of South Texas, Houston, December 3-5, 1946. Secretary, 229 Medical Arts Building, Houston.

SOUTHWEST ALLERGY FORUM

Approximately 120 members of the Southwest Allergy Forum met in Houston on April 8-9 for the following scientific program:

APRIL 8

The Life Cycle of the Allergic Individual—Dr. Paul D. Fleming, Houston.
Discussion—Dr. Homer E. Prince, Houston.
Allergic Causes of Pruritis Ani—Dr. F. R. Rugeley, Wharton.
Discussion—Dr. Wade Harris, Houston.
Hay Fever (panel discussion)—Dr. Herbert J. Rinkel, Kansas City, Mo., leader; Dr. H. Whitney Boggs, Shreveport, La.; Dr. M. H. Brodkey, Omaha, Neb.; Dr. Fannie Lou Leney, Oklahoma City, Okla.
Luncheon Discussions:
Benadryl—Dr. Ralph Bowen, Houston.
Doryl (or Carbachal in Migraine)—Dr. T. C. Terrell, Fort Worth.
Penicillin—Dr. Michael Zeller, Chicago.
The Relative Value of the Eosinophile in Pediatrics—Dr. W. L. Rucks, Memphis, Tenn.
Discussion—Dr. A. H. Braden, Houston, and Dr. L. O. Dutton, El Paso.
Asthma (panel discussion):
The House Dust Factor in Bronchial Asthma—Dr. B. G. Efron, New Orleans.
Reciprocal Influences of Bronchial Asthma and Pregnancy—Dr. Vincent J. Derbes and Dr. W. A. Sodeman, New Orleans; Dr. H. T. Engelhardt, Houston.
Practical Aspects of Food Allergy—Dr. T. G. Randolph, Chicago.
The Pharmacology of Drugs Used in the Treatment of Allergy (address at dinner)—Dr. Chauncey Leake, Vice-President and Dean, University of Texas School of Medicine, Galveston.

APRIL 9

Classification of Headaches, with Particular Reference to Management—Dr. Philip M. McNeill, Oklahoma City, Okla.
Discussion—Dr. William L. Marr, Galveston.
Urticaria (round-table discussion)—Dr. I. S. Kahn, San Antonio, leader; Dr. J. Harvey Black, Dallas, coordinator.
Conditions Producing Dyspnoea Which Have Been Diagnosed As Asthma—Dr. H. Whitney Boggs, Shreveport, La.
Discussion—Dr. Dudley Youmans, Shreveport, La.
Use of Sulfa Drugs in Prevention and Treatment of Infective Episodes in Bronchial Asthma—Dr. Paul T. Petit, Beaumont.
Discussion—Dr. George Seibold, Houston.
Luncheon Discussions:
Tyrothricin—Dr. Henry Ogden, New Orleans.
Privine—Open discussion.
Other Drugs—Open discussion.
Contact Dermatitis—Dr. Bedford Shelmire, Dallas.
Discussion—Dr. Homer E. Prince, Houston.
Histamine and Antihistamine Agents: Their Use in Clinical Medicine (motion picture)—Dr. Bayard T. Horton, Mayo Clinic, Rochester, Minn.

In a business session the morning of April 9, the following officers were elected: Dr. W. H. Browning, Shreveport, La., chairman; Dr. Sim Hulsey, Fort Worth, secretary-treasurer. The next meeting will be in Shreveport, La., in April, 1947.

Drs. Ralph Bowen, Albert Braden, Paul D. Fleming, and Homer E. Prince composed the Houston committee on arrangements. This committee plus Drs. DeWitt Hotchkiss and George J. Seibold, Houston; William L. Marr, Galveston; Paul T. Petit, Beaumont; and F. R. Rugeley, Wharton, were hosts at a cocktail party for members and visitors at the home of Dr. Braden the evening of April 7.

Due to improved methods of case-finding and more widespread knowledge about the disease, tuberculosis did not increase in this country during the war, though it rose to alarming proportions in Europe and Asia. Nevertheless, it is deplorable that tuberculosis took more than 205,000 American lives during the war years.—Harry S. Truman.

CONFERENCE OF CITY AND COUNTY HEALTH OFFICERS

City and county health officers of Texas met in Galveston on May 6 for a conference under the direction of Dr. George W. Cox, state health officer.

The program announced in the April, 1946, JOURNAL was modified as follows: Dr. Reginald M. Atwater, executive secretary of the American Public Health Association, New York, was unable to appear because of illness. Dr. J. V. Irons, Austin, reported on an outbreak of "Q" fever instead of influenza B. Dr. W. M. Brumby, Houston, presented a paper, "Yellow Fever," to substitute for the paper scheduled by Dr. Carl Moore, Austin. Mr. Martin Wukasch read the paper by Mr. Robert W. Harding, San Antonio, who was unable to be present.

TEXAS ASSOCIATION OF MEDICAL ANESTHETISTS

Approximately thirty-eight attended the meeting of the Texas Association of Medical Anesthetists in Galveston on May 6, at which the following officers were elected: president, Dr. Claudia Potter, Temple; vice-president, Dr. J. C. Youngblood, Houston; secretary-treasurer, Dr. Russell Bonham, Houston; and president-elect, Dr. R. A. Miller, San Antonio.

The program as given in the April, 1946, number of the JOURNAL was carried out.

The next meeting of the Association will be held in Dallas immediately preceding the 1947 annual session of the State Medical Association.

TEXAS PUBLIC HEALTH ASSOCIATION

The Texas Public Health Association held its twenty-first annual meeting in Austin on May 26-29. In addition to business meetings, general sessions, and social events, meetings were held for sections of health officers, nurses, sanitary engineers, laboratory workers, sanitarians, and clerks. A public health exhibit, including late films on public health procedures, and a display of modern record-keeping equipment were available for inspection. Tours of the State Health Department facilities were also arranged for the visitors.

Among out-of-state participants on the program were Lewis E. Dodson, Ann Arbor, Mich., president of the association; Miss Ellen B. Whiteman, New York, N. Y.; Dr. Justin A. Andrews, Mark Hollis, and John S. Wiley, all of Atlanta, Ga.; Dr. Gustavo A. Reverosa, state of Tamaulipas, Mexico; and Miss Carrie Mandenhall, Washington, D. C.

Dr. L. P. Walter, Austin, succeeds to the presidency, having served during the past year as president-elect. Other officers are as follows: Dr. S. W. Bohls, Austin, president-elect; Miss Ella Patton, Dallas, first vice-president; Dr. George A. Gray, San Angelo, second vice-president; Earle W. Sudderth, Dallas, secretary.

The next meeting of the association will be in Dallas. The date will be determined later.

TEXAS CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

Thirty-one members and twenty-six visitors registered for the fifth annual meeting of the Texas Chapter of the American College of Chest Physicians, held in Galveston on May 6. The program as given in the April, 1946, JOURNAL was carried out except that Dr. C. M. Hendricks, El Paso, president-elect of the American College of Chest Physicians, was unable to be present and Dr. Robert Homan, El Paso, read the address which he had prepared.

The recommendations of the nominating committee, headed by Dr. Charles J. Koerth, Junction, were accepted by acclamation. The new officers are Dr. R. G. McCorkle, San Antonio, president; Dr. H. Frank Carman, Dallas, first vice-president; Dr. Robert Homan, El Paso, second vice-president; and Dr. Elliott Mendenhall, Dallas, secretary-treasurer.

A telegram of congratulations from Dr. J. Arthur Myers, president of the American College of Chest Physicians, was read, and announcement was made of the national meeting to be held in San Francisco on June 27-30.

The treasurer's report showed a balance on April 30, 1946, of $37.20. The chapter voted to increase annual dues to $2.

An amendment to the By-Laws was adopted, making the five immediate past presidents of the chapter, the regent, and the governor of the state an executive committee for the chapter, the duties of this committee being to assist the officers in conducting the affairs of the chapter and to lend counsel and advice to the officers in strengthening the program for the chapter.

TEXAS CHILD HEALTH COUNCIL

A meeting of the Texas Child Health Council was called by the vice-chairman, Dr. T. J. McElhenney, Austin, the morning of May 9 at Galveston, at the time of the annual session of the State Medical Association. Those in attendance were Drs. McElhenney; C. O. Terrell, Fort Worth; H. L. Moore, Dallas; A. E. Hansen, Galveston; Francis Garbade, Galveston; F. P. Helm, Austin; and George M. Decherd, Galveston. Guests were Dr. James L. Wilson, professor of pediatrics, University of Michigan Medical School, and Miss Helen T. Konjias.

A schedule of postgraduate courses in pediatrics was reviewed in relation to other medical meetings, and the proposed period from October 28 to November 3 was found agreeable. Another course was proposed for the spring of 1947.

It was agreed that a brochure for the child health program should be prepared. Emphasis was again placed on the need for more children's hospitals to combat the serious child health situation in Texas, but it was agreed that efforts should first be directed towards providing for teaching needs.

An extensive discussion of the study of child health conditions being made by the American Academy of Pediatrics was held. It was pointed out that the need for such a survey was sufficient that a study would be made by some agency, and that the American Academy preferred to initiate the program before some nonmedical group took action. The council expressed disappointment that the State Medical Association had failed to take action endorsing such a study and that the Texas Pediatric Society had not officially done so as yet, and emphasized that the only connection the Children's Bureau of the Department of Labor in Washington had with the survey was to furnish statistical clerks and machines. Dr. Wilson, who was a member of the original "committee of nine" of the American Academy of Pediatrics which worked out plans for the survey, said that no money was being received from the Children's Bureau or the U. S. Public Health Service and that the survey would definitely be made by the academy, which would make the results publicly available. Suggestions were made for securing financial aid from the Texas Pediatric Society, the Borden Company, and other sources, but no conclusions were reached before adjournment to attend scientific sessions of the State Medical Association.

TEXAS NEUROPSYCHIATRIC ASSOCIATION

The Texas Neuropsychiatric Association was the guest of the Texas Psychopathic Hospital in Galveston on May 6, with seventy-three members registered. The program appearing in the April, 1946, JOURNAL was followed, with Dr. Titus H. Harris, Galveston, president, presiding.

In a business session at the conclusion of the scientific program Dr. Fred T. Rogers, Dallas, was elected president; Dr. Jack Ewalt, Galveston, vice-president; and Dr. David Wade, Austin, secretary-treasurer. Upon motion by Dr. A. J. Schwenkenberg, Dallas, the association decided to dispense with its customary November meeting this year. The next meeting will be next May in conjunction with the 1947 annual session of the State Medical Association in Dallas.

At the request of Dr. Harry S. Rubin, of the Veterans Administration, a committee was appointed to recommend the fees to be charged for the examination and treatment of veterans referred by the Veterans Administration to nongovernmental physicians. This committee includes Drs. Schwenkenberg; Guy F. Witt, Dallas; and A. Hauser, Houston.

Cocktails and dinner were served at the Balinese Room following the business meeting.

TEXAS SOCIETY OF PATHOLOGISTS

The Texas Society of Pathologists held a business meeting in Galveston on May 8, at which time it was decided to hold the next regular session in Houston in January, 1947. Seventeen members and seven guests were present. Dr. May Owen, Fort Worth, president, presided.

No separate scientific program was presented, but members of the society participated in the program of the Section on Clinical Pathology of the State Medical Association on May 7-8.

HOSPITALS NEEDING INTERNS AND RESIDENTS

Methodist Hospital, Dallas. Capacity 206 beds. C. B. Fielder, Superintendent; (2 interns now).

El Paso City County Hospital, El Paso. Capacity 192 beds. George W. Cook, Col., U. S. A., Ret., Superintendent; (3 interns for one year term, graduates of class A medical schools only, July 1).

TEXAS RAILWAY AND TRAUMATIC SURGICAL ASSOCIATION

The program of the thirtieth annual meeting of the Texas Railway and Traumatic Surgical Association as announced in the April, 1946, JOURNAL was presented in Galveston on May 6, with 147 members and three guests in attendance. Dr. O. Theron Clagett, Mayo Clinic, Rochester, Minn., was guest of honor.

In addition to the scientific papers scheduled for the program, Dr. G. W. N. Eggers, Galveston, presented lantern slides illustrating the atrophy which occurs in the fractured ends of long bones and the resulting separation of the fragments when the usual bone plates have been applied, and others showing a new metal plate with slots instead of screw holes which allow longitudinal motion of the bone, thereby promoting union as the normal muscle pull keeps the bone ends closely approximated while atrophy develops.

Dr. Charles E. Collins, Waco, showed slides illustrating a pin which he uses for internal fixation of fractures of the neck of the femur and motion pictures of patients illustrating the functional results of using the pin.

Discussion of the papers was participated in by Drs. J. R. Phillips, Houston; William Hibbitts, Texarkana; W. C. Smith, Corpus Christi; A. L. Ridings, Sherman; J. H. Dameron, Livingston; Frank R. Denman, Houston; F. L. Snyder, Fort Worth; P. R. Denman, Houston; Ross Trigg, Fort Worth; D. C. Brindley, Kingsville; O. T. Clagett, Rochester, Minn.; Sam Dunn, Lubbock; and George Enloe, Fort Worth.

In a business meeting at the conclusion of the scientific program, the following officers were elected: Dr. F. L. Snyder, Fort Worth, president; Dr. Lynwood H. Denman, Lufkin, first vice-president; Dr. Denman C. Hucherson, Houston, second vice-president; and Dr. Ross Trigg, Fort Worth, secretary-treasurer.

The secretary-treasurer reported a cash balance May 3, 1946, of $630.40 in addition to $356.31 in a savings account and two United States war bonds with maturity value of $1,500. Disbursements during the preceding fiscal period, including $1,240 for the bonds, totaled $2,531.83. During the meeting $125 in dues was collected.

A resolution was passed in appreciation of the efforts of Dr. Peyton Denman, Houston, in collecting $582.50 from members of the association in South Texas to help defray the expense of the barbecue held following the scientific and business sessions, and of the generous contributions of the members to the fund.

TEXAS SOCIETY OF GASTRO-ENTEROLOGISTS AND PROCTOLOGISTS

The Texas Society of Gastro-Enterologists and Proctologists in session May 6 at Galveston elected the following officers: Dr. Tom E. Smith, Dallas, president; Dr. George M. Underwood, Dallas, vice-president; Dr. Hugh Beaton, Fort Worth, vice-president; and Dr. D. L. Curb, Houston, secretary-treasurer. The gastro-enterologists elected Dr. Edward Lefeber and Dr. Charles T. Stone, both of Galveston, to membership, and the proctologists elected Dr. John McGivney, Galveston, and Dr. P. M. Waltrip, Fort Worth, to membership.

The program listed in the April, 1946, JOURNAL was presented. Discussions of the papers were opened by the following: Dr. Guy F. Witt, Dallas (paper by Dr. Titus Harris); Dr. M. Herbert Barker, Chicago (paper by Dr. Charles T. Stone); Dr. Herbert T. Hayes, Houston (paper by Dr. John McGivney); Dr. C. O. Patterson, Dallas (paper by Dr. Edward Lefeber); Dr. Hugh Beaton, Fort Worth (paper by Dr. Edgar Poth). A dinner for members and guests was held at the conclusion of the scientific program.

The society plans to meet next on the Monday preceding the annual session of the State Medical Association in Dallas in May, 1947.

TEXAS STATE HEART ASSOCIATION

More than one out of every five deaths in Texas during 1945 was caused by heart disease, according to figures presented by Dr. Victor E. Schulze, San Angelo, before the meeting of the Texas State Heart Association in Galveston on May 6. The proportion of deaths from this cause last year was nearly three times as great as that twenty years ago, and the chances of dying from heart disease at the present time are more than double that of cancer and about three times that of accidents and apoplexy.

Based on the above statistics, a motion made by Dr. Schulze and seconded by Dr. George R. Herrmann, Galveston, authorizing the executive committee to explore ways and means of activating the Texas State Heart Association commensurate with the increasing importance of heart disease in Texas was approved by the association.

About seventy persons were present for the program announced in the April, 1946, number of the JOURNAL. They elected unanimously the following new officers: Dr. Robert M. Barton, Dallas, president; Dr. Hatch W. Cummings, Houston, vice-president; and Dr. M. B. Whitten, Dallas, secretary-treasurer.

The association passed motions requesting the new president to appoint two new state committees, one to prepare and sponsor programs designed to create interest in heart disease generally and rheumatic fever particularly for county and district medical societies, and one to work with similar committees from the Texas Pediatric Society and the Crippled Children's Service in formulating a program for the

care of children with rheumatic fever to be presented to the Children's Bureau.

It was agreed that the president or the secretary or both would be sent as delegates to the meeting of the American Heart Association in San Francisco in June, and that the president would also appoint other members of the association as representatives. The secretary announced that Dr. Schulze had been appointed to the Committee on Policies of the American Heart Association.

The Texas State Heart Association will hold its 1947 meeting in Dallas immediately preceding the annual session of the State Medical Association.

NEW ANTIMALARIAL: SN 7618

A two-year study of a new antimalarial drug, chloroquine, also known as SN 7618, reveals that it is an effective suppressive agent but does not cure malaria, according to a report released by the Board of Coordination of Malarial Studies.

R. F. Loeb, M. D., of New York, Chairman, and his associates, writing in the April 20 issue of *The Journal of the American Medical Association*, say that they found toxic reactions to the drug, which included mild and transient headache, visual disturbances, intense itching, and gastrointestinal complaints, following doses adequate for treatment of acute attacks.

In studying approximately 5,000 individuals who received SN 7618, the authors write that they found "in a small number of instances, usually with dosages higher than necessary for either treatment or suppression, individual subjects have refused to continue drug administration because of unpleasant symptoms. None of these manifestations has been constitutionally serious and all have been readily reversible. Unlike quinacrine (atabrine), SN 7618 does not discolor the skin."

Continuing with their comparison of the two antimalarial drugs the authors say that like atabrine, SN 7618 does not produce permanent cures. SN 7618 is absorbed somewhat more rapidly than atabrine, and it is highly active against two of the most widely distributed malarial types—vivax and falciparum. However, the authors state, "it does not prevent relapses in vivax malaria even when administered in doses many times those required to terminate an acute attack, nor will it prevent the establishment of vivax infection when administered as a prophylactic. It is highly effective in vivax malaria as a suppressive agent and in the termination of acute attacks, significantly lengthening the interval between treatment and relapse beyond that observed with quinacrine or quinine. In falciparum malaria it has been demonstrated to suppress the acute attack and to effect complete cure of the infection. Studies of the antimalarial activity of SN 7618 against well standardized strains of P. vivax and P. falciparum have shown its activity to be approximately three times that of quinacrine."

In the majority of patients, treatment with this drug will reduce the temperature to normal within 24 hours and the remainder within 48 hours.

SODA FOR WOOD ALCOHOL POISONING

Four Navy doctors, who made a study of methyl (wood) alcohol poisoning, believe the essential principle of treatment is the correction of acidosis with an alkali, such as soda.

The doctors, who reported this study in the January 12 issue of *The Journal of the American Medical Association*, are: Commander W. B. Chew, Commander E. H. Berger, Captain O. A. Brines, and Captain M. J. Capron, of the United States Naval Reserve.

Of 31 military personnel patients suffering from wood alcohol poisoning and under the care of these doctors, five died within three hours after admission to the hospital. The rest recovered and were returned to duty. The authors felt that their success was due to the prompt elimination of acidosis, sometimes called acid intoxication.

LIBRARY NOTES

The package library consists of collections of reprints and other periodical material on various subjects, prepared for lending to members of the Association. Requests for packages should be addressed "Library, State Medical Association of Texas, 1404 W. El Paso Street, Fort Worth, Texas." Twenty-five cents in stamps should be enclosed with the request to cover postage and part of the expense of collecting the material. Only one package may be borrowed at a time, and packages are allowed to remain in the hands of the borrower for 14 days.

Package Service

Packages were mailed from the Library of the State Medical Association during May, as follows:

Dr. Sidney W. Hughes, Brownwood—*Hayfever, diagnosis and therapy* (38 articles).

Dr. L. Villareal, El Paso—*Blood Pressure, High, therapy* (12 articles).

Dr. William R. Klingensmith, Amarillo—(1 journal).

Dr. S. Joe McKinsey, McAllen—*Blood Pressure, High, therapy* (17 articles).

Dr. Elliott Mendenhall, Dallas—*Tuberculosis, economic and social aspects* (12 articles).

Dr. J. D. Magee, Abilene—*Eyelids, cancer* (8 articles); *Eyes, foreign bodies* (10 articles).

Dr. M. W. Caskey, Wichita Falls—*Thrombo-Angiitis, obliterans* (9 articles).

Dr. Ernestine Smith, Amarillo—*Colon, dilatation* (12 articles); *Headache, therapy* (9 articles).

Dr. O. R. O'Neill, Paris—*Rubella* (5 articles).

Dr. Harley C. Sullivan, Burkburnett—*Rubella* (5 articles).

Dr. W. D. Anderson, San Angelo—*Histoplasmosis* (14 articles).

Dr. J. M. Woodall, Big Spring—*Snakes, bites* (10 articles); *Meningitis, pneumococcic* (25 articles).

Dr. C. A. Smith, Texarkana—*Bones, fragility* (12 articles).

Dr. Ernest S. Sears, Houston—*Varicose Veins, therapy* (7 articles).

Dr. P. S. Joseph, Alice—*Erythroblastosis, fetal* (11 articles).

Dr. W. M. Boguskie, Hearne—*Paralysis, spastic* (11 articles).

Dr. F. J. L. Blasingame, Wharton—*Blood, prothrombin* (8 articles); *Blood, magnesium* (5 articles).

Dr. B. D. Alexander, Waco—*Poliomyelitis, epidemiology and statistics* (5 articles).

Dr. L. R. Byrd, Port Arthur—*Ammonia, toxicity* (3 articles).

Dr. Grady Bruce, Sulphur Springs—*Thyroid, hyperthyroidism* (15 articles); *Prostate, hypertrophy* (11 articles).

Dr. O. E. Steck, Bellville—*Measles, therapy* (9 articles).

Dr. S. C. Arnett, Lubbock—*Intussusception* (20 articles).

Dr. Malcolm Jones, Baytown—*Extremities, blood supply* (17 articles).

Dr. F. E. Dye, Bay City—*Ethics, medical* (5 articles).

Dr. O. Garcia, McAllen—*Spiders, bites* (15 articles).

Providence Hospital, Waco—*Lungs, abscess* (12 articles).

Dr. C. R. Johnston, San Angelo—*Dermatitis, venenata* (22 articles).

Dr. H. W. Dietrich, El Paso—(2 journals).

Dr. J. W. Neely, Presidio—*Uranium, toxicity* (5 articles).

Dr. W. S. Parks, Breckenridge—*Pemphigus* (15 articles).

Dr. E. Spier, El Paso—(1 journal).

Dr. B. L. Burditt, Del Rio—*Curare* (8 articles).

Dr. D. R. Swetland, Marlin—*Backache* (16 articles).

Dr. C. G. Brindley, Kingsville—*Surgery, post-operative care* (9 articles).

Dr. George A. Gray, San Angelo—*Tonsillectomy and Poliomyelitis* (11 articles).

Dr. William R. Whitehouse, Cleburne—(2 journals).

Dr. George Y. Swickard, Orange—*Splenectomy* (7 articles).

Dr. R. C. Atmar, San Antonio—*Sclerosis, disseminated* (12 articles).

ACCESSIONS

Philadelphia, W. B. Saunders Company—Graybeil and White: Electrocardiography in Practice, second edition.

New York, Grune & Stratton—Spiesman: Essentials of Clinical Proctology.

Philadelphia, J. B. Lippincott Company—A Bibliography of Infantile Paralysis.

SUMMARY

REPRINTS RECEIVED, 597.	LOCAL USERS, 47.
JOURNALS RECEIVED, 206.	BORROWERS BY MAIL, 38.
ITEMS CONSULTED, 226.	PACKAGES MAILED, 43.
ITEMS TAKEN OUT, 208.	ITEMS MAILED, 464.

TOTAL ITEMS CONSULTED AND MAILED, 898.

MOTION PICTURE LENDING LIBRARY

Motion picture films on medical subjects, 16 mm., both silent and sound, some in color, and suitable for either medical or lay audiences, are available for loan to county medical societies, hospital staffs, or individual physicians, on request. Borrowers will be required to pay only the cost of shipment of the films, by express, with insurance, and for any damage to films while in the hands of the borrower.

Requests for films should be addressed to "Motion Picture Lending Library, State Medical Association of Texas, 1404 West El Paso Street, Fort Worth 3, Texas." A list of available films, with descriptions, will be furnished on request.

The following motion picture films were loaned by the Motion Picture Lending Library of the State Medical Association during May:

Choose to Live (Available through the courtesy of the U. S. Public Health Service and the American Society for the Control of Cancer)—Public Health Department, Fort Worth.

Eyes for Tomorrow (Available through the courtesy of the Hurst Eye, Ear, Nose and Throat Hospital-Clinic, Longview)—Public Health Group, Galveston.

From Moo to You (Available through the courtesy of the Borden Company, New York)—Public Health Department, Fort Worth, and Public Health Group, Galveston.

Immunization (Available through the courtesy of Lederle Laboratories, Inc., New York)—Public Health Group, Galveston.

Malaria—Falls County Medical Society, Marlin.

Poliomyelitis, Sister Kenny Method of Treatment (Available through the courtesy of Dr. Herbert Hipps, Waco)—Rotary Club, Ranger.

Report to the People (Available through the courtesy of the National Foundation for Infantile Paralysis)—Rotary Club, Ranger.

Story of D. D. T. (Available through the courtesy of British Information Services)—Jefferson County Health Department, Beaumont.

NEWS

Contributions to this department will be appreciated. News should be of general medical interest, such as public health activities, new hospitals, personal items of more than local value, etc. News for a particular number of the JOURNAL should be in the hands of the Editor not later than the fifteenth of the preceding month.

Meetings of Out-of-State Organizations.—Announcements have been received of various national and regional meetings within the next few months of interest to physicians. Among such meetings are the following:

American Association for the Study of Goiter: Chicago, June 20-22. The Drake Hotel will be headquarters for a three-day session of scientific papers on various phases of thyroid diseases and therapy, social affairs, and a business session. Dr. Johannes Wahlberg, Helsingfors, Finland, will be among the speakers, and Dr. Brown M. Dobyns, Rochester, Minn., will present the Van Meter Prize Award essay.

National Gastroenterological Association: New York, June 19-21. Five symposia, five additional short papers, and two luncheon round-table conferences (one on "Parasitology and Tropical Medicine from a Military and Civilian Standpoint," and one on "Socialized Medicine") will be featured as the association resumes its annual scientific sessions.

American College of Radiology and American Radium Society: San Francisco, June 29-30. The college will hold a business session and a banquet, featuring the address of Dr. Lowell S. Goin, Los Angeles, president, at the Palace Hotel on June 29. The Radium Society, previously announced for June 30 and July 1, will instead meet June 29-30 in the Assembly Hall of the San Francisco Health Center.

Rocky Mountain Radiological Society Mid-Summer Conference: Denver, August 8-10. Drs. John Camp, Rochester, Minn.; William E. Costolow, Los Angeles; Ross Golden, New York City; and Dabney Kerr, Iowa City, Iowa, will be guest speakers when this annual conference is resumed. All physicians interested in radiology are invited.

American Congress of Physical Medicine: New York, September 4-7. The twenty-fourth annual scientific and clinical session will be held at the Hotel Pennsylvania. All scientific and clinical sessions, which will be held each day, will be open to any member of the medical profession in good standing with the American Medical Association. Annual instruction courses will be held September 4-6. Physicians and therapists registered with the American Registry of Physical Therapy Technicians are eligible for the courses.

American Hospital Association: Philadelphia, September 30-October 3. The forty-eighth annual convention and postwar conference will have headquarters at the Philadelphia Commercial Museum, Exhibition and Convention Hall.

American College of Surgeons: New York, September 9-13. The first clinical congress since 1941 will be held at the Waldorf-Astoria. Plans include demonstrations, scientific sessions, panel discussions, symposia, forums, Hospital Standardization Conference, medical motion pictures, business meetings, and educational and technical exhibits. Operative and nonoperative clinics will also be held at local hospitals.

International College of Surgeons, United States Chapter: Detroit, October 21-23. The eleventh annual assembly and convocations will open with surgical clinics in Detroit hospitals. Thereafter meetings and exhibitions will be held in the Masonic Temple. Among the principal speakers will be Hamilton Bailey, London, England; Dr. Francisco Grana, Peru; Dr. Felipe F. Carranza, Argentina; Dr. Manuel Manzanilla, Mexico; and Dr. Wayne W. Babcock, Philadelphia.

The Journal of the Kansas Medical Society has a new editor, Dr. Lucian R. Pyle, Topeka, who has been a member of the editorial board for eleven years. Dr. Pyle succeeds Dr. W. M. Mills, editor for the past eleven years, who resigned to assume the presidency of the Kansas Medical Society.

Rheumatic Fever and Rheumatic Heart Disease will receive the concerted attention of the American Legion and Legion Auxiliary in a program of research and treatment to which $25,000 has already been allocated by each group. The announcement that plans formulated recently by the American Legion Medical Advisory Board, headed by Dr. Leonard G. Rowntree, former chief of the medical division of the Mayo Clinic, would be put in effect shortly stated that 50 per cent of funds available have been earmarked for a comprehensive program to render the rheumatic diseases reportable, a case-finding program among school children and communities, an immediate and life guidance program for the prevention of the disease and for care of victims, treatment, convalescent care, vocational rehabilitation and training, and job placement. The remaining 50 per cent will be utilized in research into the relationship of bacteria to the incidence of primary and repeated attacks of the afflictions. A full time traveling executive secretary will be appointed and a fellowship in some prominent medical research center will be established to help ascertain the true status of the diseases. It was pointed out that rheumatic fever, with its effects upon the heart, causes more deaths and more invalidism up to the age of 16 than any other disease, and that even up to the age of 26 rheumatic fever and heart disease is second only to tuberculosis in the causes of death.

The Gonzales Warm Springs Foundation expansion program was initiated with the dedication April 28 of a $75,000 doctors and nurses residence, state the McAllen *Monitor*. The residence was sponsored by the Texas junior groups of the Daughters of the American Revolution.

The National Medical Service Society organized an East Texas Chapter in Tyler on May 3. The new group of medical service representatives covers eighteen counties, according to the Tyler *Courier-Times*. The national meeting of the society was held in Dallas May 24-25.

The New Juarez, Mexico, Health Center was officially opened April 29, according to the El Paso *Herald-Post*. The center was planned and built as a coöperative venture by the Institute of Inter-American Affairs and the Mexican Ministry of Health. The border health program is being carried on by similar coöperation. The new center will be equipped and manned for the treatment of tuberculosis, venereal disease, children's disease, and prenatal care, and will be headquarters for the tuberculosis and venereal disease programs for the entire border area. The dedication of the new center was part of the program of the United States-Mexico Border Public Health Association meeting in El Paso.

Methodist Hospital at Houston honored Dr. Marvin L. Graves, 79, and Dr. John T. Moore, 82, for their eminence in the medical profession and because they are "friends of mankind" when the board of trustees and medical staff of the hospital awarded the two Houston physicians certificates of membership to the honorary staff of the hospital April 23. Bishop A. Frank Smith, presiding Methodist bishop in the Houston area, praised both men at the dinner in the Houston Country Club at which the certificates were presented, the Houston *Press* and *Post* report. Raymond P. Elledge, toastmaster and chairman of the hospital board, outlined plans for the three hundred bed hospital in the Texas Medical Center which the Texas Methodist Conference expects to build. The new hospital, to cost between $2,400,000 and $3,000,000, will be erected on land donated by the M. D. Anderson Foundation. Already $1,000,000 for the hospital has been donated by Mr. and Mrs. H. R. Cullen, and the Anderson Foundation has agreed to give 50 cents for every dollar raised up to $500,000.

A Veterans Administration Hospital at Big Spring is one of eight hospitals authorized for the immediate future, according to *The Journal of the American Medical Association*. Plans and specifications are being set up for the 250 bed general medical unit, approximate cost of which will be $2,570,753.

The Western Clinic Hospital, Midland, has been sold by Dr. Waldo Leggett to three staff physicians, Drs. J. M. Devereux, H. B. Johnson, and D. L. Patton, all of Midland. The Midland *Reporter-Telegram* indicates that when the hospital was established in 1938 it contained only six beds. It was later enlarged to twelve, and during the war to twenty-seven. Dr. Leggett had owned the property more than seven years.

The Floeckinger Hospital Building, Taylor, is being reconverted to medical use after having been used for apartments since 1936, states the Taylor *Press*. Built in 1911 by Dr. H. R. Floeckinger, the property is now owned by Dr. J. J. Johns, who will open the building for clinic and laboratory work.

Medical Office Space in Abilene was made available in May in the former Fifth Street U. S. O. building, reports the Abilene *News*. Drs. Floyd Taylor, R. W. Varner, T. Wade Hedrick, O. W. Little, Guy L. Pattillo, Virginia Boyd, L. J. Webster, Jack Crow, George D. Thurman, and J. D. Magee expected to take over office space together with three dentists, a clinical laboratory, and a prescription pharmacy. The business operations of the tenants will be handled individually and not as a clinic.

A **Hospital Improvement Program** for Austin to cost $3,000,000 is favored by local physicians who recommended to city officials that bonds for that amount be included in a forthcoming city bond issue which may total $17,000,000, informs the Austin *American*. The $3,000,000 expenditure was voted for by the Travis County Medical Society and by doctors at Brackenridge Hospital, the present city hospital, but when the request was submitted to planning authorities, it was reduced by one-half. A delegation of doctors attended a meeting with city officials the middle of April at which time they flatly rejected the lower figure and warned that the health situation in Austin is acute and that an epidemic would be extremely dangerous under present circumstances. A city planning commission, Chamber of Commerce planning bureau, and public meeting will consider the recommendations before the final bond issue is drawn up.

Additional Doctors for the Veterans Administration are urgently needed because of the recent opening of regional offices in the Southwest, reports the Dallas office. The need now is for 400 physicians to serve on disability rating board, which pass on claims for disability made by veterans. The positions carry a starting salary of $5,180 a year plus overtime. Part-time positions are also available. Applications are being received at Veterans Administration regional offices in Dallas, San Antonio and Houston; hospitals in Dallas, McKinney, Amarillo, Legion, and Temple; and the Veterans Administration Center in Waco.

A **San Angelo School Health Improvement Institute** has been arranged by Dr. W. A. Buckner of the State Health Department, for next fall, Dr. George A. Gray, director of the San Angelo-Tom Green County Health Unit, told the San Angelo *Standard*. The institute program will include in-

struction in screening of school children for physical defects and attempts to improve school lighting and sanitary facilities.

El Paso Physicians were invited to attend clinical sessions April 5-6 at William Beaumont General Hospital, conducted by Dr. Sterling Bunnell, hand surgery consultant to the Secretary of War. Dr. Bunnell was a pioneer in the correlation of orthopedics, plastic, and neurologic surgery. The invitation was extended by Col. George W. Reyer, commanding officer of the hospital, informs the El Paso *Times*.

Texas Medical Center.—A drive for $3,750,000 necessary to complete the $6,250,000 needed for the University of Texas units in the Texas Medical Center at Houston is under way by a Houston Chamber of Commerce committee seeking donations from business, industrial, and professional sources and a University of Texas Development Board committee contacting University ex-students for contributions. Houston newspapers report excellent results in the initial stages of the campaign, some $400,000 being pledged by May 10.

Application for construction of a $2,000,000, fourteen story doctors and dentists office building in the Texas Medical Center was filed with the civilian production administration in April, with the hope that approval would be granted and construction might begin immediately, states the Houston *Post*. All plans were already completed and a contractor tentatively approved when the application was filed.

The Baylor Free Diagnostic Center has been established at Baylor University Hospital, Dallas, to serve charity cases from throughout the Southwest, according to announcement by Administrator Lawrence Payne. Services of the highly specialized diagnostic center will be available to any sick person, regardless of residence, who cannot afford to pay for specialized study and treatment of his case.

Aim of the center is to give prompt application of the newest advances in medical science to sick people who otherwise could not obtain these benefits because of financial expense. The center's work will be of especial help to doctors in small towns who do not have the facilities for diagnosing unusual and difficult cases. The center will also be the nucleus for Baylor's teaching program for residents, interns, nurses, technicians, anesthetists, and other professional and technical students.

Approximately 150 practicing physicians of Dallas, including specialists in all fields of medicine, compose the Baylor medical staff which will give service in the clinic and will be available for examination, diagnosis, consultation, and to prescribe treatment. Dr. Henry M. Winans is chairman of the hospital's medical board and the out-patient service committee is composed of Dr. Lyle M. Sellers, chairman, Dr. Felix L. Butte, and Dr. Robert Sparkman.

The free diagnostic center will constitute an enlargement and expansion of Baylor's previous charity service, which last year totaled $132,790.37. Because of the institution's extensive physical facilities and active research program, directed by outstanding medical men of the Southwest, difficult cases are brought to Baylor from throughout the area. In many instances these patients have already spent their life savings trying to regain health and need to be cared for further without charge, Mr. Payne said. The center's work will be of diagnostic and clinical nature only and those patients requiring hospitalization will come in through regular channels, as in the past.

Income from maintenance of the center will be derived from Baylor's limited endowment, other individual gifts, appropriations from the Baptist General Convention and from the annual Mother's Day Hospital Fund collections in Baptist Churches of Texas.

Southwestern Medical College.—Roscoe P. DeWitt, Dallas, has been named architect for the Southwestern Medical College's $1,000,000 initial building, states the Park Cities *News*. Working drawings will be completed as soon as possible and construction will start as soon as materials and labor are available. Dr. Christopher Parnell, nationally famous medical architect of Rochester, N. Y., was appointed medical consultant to see that the college building is planned to facilitate medical training and research. Funds for the initial building were provided by Dallas citizens in 1943. The first unit will provide facilities for approximately 250 students and will include the Braniff Research Laboratories for which the Braniff Foundation donated $100,000 last December. The building will be erected on land provided by Karl Hoblitzelle, Dallas, in memory of the late Mrs. Esther Hoblitzelle. Mr. DeWitt and Dr. Parnell had been named previously to similar positions in connection with a Dallas City-County Hospital, $7,000,000 in bonds for which were approved last summer.

Sixty-four new students have been accepted for the class beginning September 30, Dr. Donald Slaughter, dean of students at Southwestern Medical College, has announced. This group will constitute the full new class, limited in enrollment to allow adequate laboratory facilities, the proper individual instruction, and time for scientific research. According to the Oak Cliff *Tribune*, about one out of every six applications were accommodated, with preference being given to ex-servicemen, of whom forty-seven were approved. About fifty students are from Texas. The fifth class since the college was founded, this will be the first class to participate in a normal, nonaccelerated curriculum, since the Army and Navy programs have been discontinued.

Dr. Don P. Morris, recently discharged from the Army, has been appointed assistant professor of neuropsychiatry at Southwestern Medical College, reports the Dallas *News*. Dr. Morris is a graduate of Yale University and had served at Eloise Hospital, Eloise, Mich., and at the University of Louisville, Ky., before entering military service in 1942.

An advisory council for Southwestern Medical Foundation is now being organized, according to the Dallas *Medical Journal*. When complete, the council will be composed of voluntary members from five states and will be used to aid Southwestern Medical College in giving better service. North Texas is now being organized, with one lay member and one member from the medical profession in each county.

Dr. Austin E. Smith, secretary of the Council on Pharmacy and Chemistry of the American Medical Association, on April 18 was in Dallas, where he spoke to students and faculty of Southwestern Medical College and to the Dallas Salesmanship Club, informs the Dallas *News*.

University of Texas Medical Branch.—Dr. Daniel C. Darrow, Yale University, has been invited to carry on special work with the diarrhea problem at the Children's Hospital at the University of Texas School of Medicine. The invitation was extended in connection with the University's Child Health Program. It is hoped by staff members that practicing physicians of Texas will refer many infants sick with severe diarrhea to the Children's Hospital for treatment. Dr. Alice Gamble, assistant in the Department of Pediatrics, will be available for call at all times. Patients may be admitted through the University's Diagnostic Clinic whereby the hospital bill for those eligible for the service may be paid from state funds. Special arrangements may also be made for part-pay patients. Dr. Darrow has contributed much to the understanding of the water and electrolyte loss in babies with diarrhea and has advanced evidence that the loss of potassium from

the tissue cells may be fully as important as the loss of water and sodium chloride as the actual cause of death in such infants. Dr. Arild E. Hansen, chairman of the Department of Pediatrics, indicates that the studies Dr. Darrow will carry on will be correlated with the bacteriologic phase of the problem now being studied by Dr. MacDonald Fulton, visiting professor of pediatric research at the University.

The Board of Regents of the University of Texas on April 27 approved a leave of absence for Dr. Ludwik Anigstein, associate professor of preventive medicine and public health, to conduct a postgraduate course during the summer for Polish physicians in Poland at the request of the U. S. Public Health Service and Department of State, reports the Austin *Statesman*. Dr. Anigstein is a former member of the faculty at the University of Warsaw.

The Regents also approved acceptance of a $500 gift from Mrs. Laura Lee Graves Steel, Houston, to be added to the principal of the Marvin Lee Graves research fellowship in internal medicine, and $8,000 from the Lilly Research Laboratories as an additional grant for support of investigation of reticuloendothelial immune sera under the direction of Dr. C. M. Pomerat, according to the Galveston *Tribune*.

Dr. Jack R. Ewalt, professor of neuropsychiatry at the University of Texas School of Medicine, delivered papers before the American Society for Research in Psychosomatic Problems in New York City and the American Psychiatric Association in Chicago during May, informs the Austin *Statesman*.

The Medical Dames, an organization of wives of students at the University of Texas School of Medicine, entertained their husbands and the faculty of the University with a musical evening on April 8 in the auditorium of the Rebecca Sealy Nurses Residence, reports the Galveston *Tribune*.

Personals

Dr. Homer B. Johnson, Midland, was recently elected president of the Midland County Tuberculosis Association, according to the San Angelo *Standard-Times*.

Dr. Phil A. Bleakney, Harlingen, left in April for the U. S. Naval Hospital at Long Beach, Calif., where he was to receive a temporary assignment with the rank of lieutenant commander, reports the Harlingen *Valley Star*.

Dr. Frank C. Hodges, Abilene, has been appointed chairman of the medical advisory committee of the Taylor County chapter of the National Infantile Paralysis Fund, states the Abilene *Reporter-News*. Dr. W. T. Sadler, Merkel, was made vice-chairman; and Drs. Melba McNeil, Erle D. Sellers, Clinton E. Adams, and C. A. McFadden, all of Abilene, are members of the committee. Dr. McFadden is also a member of the committee appointed to aid in selecting patients to be helped by the national foundation.

Dr. H. L. D. Kirkham, Capt., M. C., U. S. N. R., was awarded the legion of merit April 25 for his work in saving the lives of Pacific battle casualties and his rehabilitation work while chief plastic surgeon at the San Diego naval hospital from 1943 to 1945, informs the Houston *Chronicle*. Dr. Kirkham, who practiced in Houston prior to the war, is back in Houston as head of plastic surgery at the Naval Veterans Hospital.

Dr. Grady Mitchell, San Angelo, attended an advanced course in cardiology at Philadelphia and then went to the annual meeting of the American College of Physicians there May 13-17, the San Angelo *Standard-Times* reports. Dr. Mitchell, prior to coming to Texas in 1935, was on the faculty of the University of Pennsylvania and was physician to the Pennsylvania Hospital.

Dr. Oliver C. Seastrunk, Orange, has been elected president of the Orange County Tuberculosis Association, informs the Orange *Leader*.

Dr. Clarence M. Cash, San Benito, was reminded of his eighty-second birthday April 19 in several ways, states the Harlingen *Valley Star*. Summoned to the Valley Baptist Hospital on a call to administer anesthesia, he found himself guest of honor at a tea, participated in by employees of the hospital, where Dr. Cash has been a staff doctor since its establishment. He was presented a fountain pen by friends at a Shrine dance at Mercedes and was given an ovation by the San Benito Rotary Club, which he helped organize.

Dr. R. A. Matthews, Malakoff, celebrated his ninety-first birthday April 17, according to the Henderson *News*.

Preston E. Harrison, Ph. D., assistant professor of bacteriology at Baylor University College of Medicine, was granted the Howard Taylor Ricketts Prize for outstanding research in chemotherapy of infectious diseases in the Department of Bacteriology and Parasitology at the University of Chicago on May 3. *The Journal of the American Medical Association* reports that the award was made to Dr. Harrison for his studies on the effect of chemotherapeutic agents on the development of immunity to experimental pneumococcic infection and the relation of immune mechanisms to bacterial chemotherapy.

Marriages

Dr. Robert S. Alcorn, Menard, was recently married to Miss Betty Jane Bauer, Cincinnati, Ohio. They are at present residing in Cincinnati, where Dr. Alcorn is taking a six-months course at the Cincinnati General Hospital and College of Medicine.

Dr. W. H. McClure, Kermit, and Miss Louise Ellett, Jennings-Ordinary, Va., were married March 31 in Kermit, where Dr. McClure is in practice.

Dr. Jack R. Walton, Midland, was married to Miss Lillian Clark, Fayette, Iowa, on March 31.

SOCIETY NEWS

Armstrong-Donley-Childress-Collingsworth-Hall Counties Society

April 19, 1946

Rheumatic Arthritis—Ben Buford, Dallas.
Coronary and Allied Heart Diseases—Hubert Hawkins, Dallas.

Armstrong-Donley-Childress-Collingsworth-Hall Counties Medical Society met at Wellington the night of April 19 for addresses by two guest speakers from Dallas.

Ben Buford, in speaking of arthritis, insisted that physicians should not tell persons suffering from this disease that nothing can be done for it, but rather should give some hope and administer such treatment as has proved to give some relief. He pointed out that there are more persons suffering from rheumatism and arthritis in the state of Massachusetts alone than there are victims of poliomyelitis in the entire United States and urged that more money be secured for study of these conditions.

Hubert Hawkins stated that while the death rate of tuberculosis and cancer has dropped appreciably, deaths from heart disease have not decreased.

Eastland-Callahan Counties Society

April 23, 1946

Some Problems in Infant Feeding—C. S. E. Touzel, Fort Worth.
Management of Prostatic Obstruction—A. Keller Doss, Fort Worth.

Eastland-Callahan Counties Medical Society met for dinner in the Blue Room of the Gholson Hotel, Ranger, on April 23 as guests of the following Ranger physicians: P. M. Kuykendall, A. W. Brazda, A. K. Wier, and C. L. Jackson.

Following the meal C. S. E. Touzel and A. Keller Doss, both of Fort Worth, spoke on the subjects named above.

Ector-Midland-Martin-Howard-Andrews-Glasscock Counties Society

April 18, 1946

(Reported by E. H. Strauss, Secretary)

Common Causes of Chest Pain—Victor E. Schulze, San Angelo.

Ector-Midland-Martin-Howard-Andrews-Glasscock Counties Medical Society met at the Scharbauer Hotel, Midland, for a steak dinner and program April 18. Twenty-one members were present.

The above scientific program was carried out, and Dr. G. S. True, Big Spring, who has entirely discontinued practice, was elected an honorary member of the society.

Kimble-Mason-Menard-McCulloch Counties Society

April 10, 1946

Eyes—William Mathews, San Antonio.
Coronary Occlusion—William W. Bondurant, San Antonio.

Kimble-Mason-Menard-McCulloch Counties Medical Society met April 10 at Rockway Courts, Brady. The above scientific program was presented following dinner.

D. W. Jordan, Brady, was elected delegate, and a public relations committee and a board of censors were appointed.

R. E. Windham, San Angelo, councilor of the Sixth District, and Mrs. Windham were guests at the meeting.

Navarro County Society

April 30, 1946

The Rh Factor in Medicine—Sol Haberman, Ph. D., Baylor University Hospital, Dallas.

Navarro County Medical Society was entertained at a chicken barbecue banquet at the Corsicana Country Club on April 30 by W. P. Brown, owner of Johnson's Pharmacy, Corsicana. The annual party, which was interrupted during the war years, marked the twenty-first anniversary of Mr. Brown's ownership of the pharmacy.

Sol Haberman, Ph. D., Dallas, discussed the Rh factor in medicine.

Dan B. Hamill, president of the society, announced that the Twelfth (Central Texas) District Medical Society would meet in Corsicana on July 9.

J. Wilson David presented some golf balls from the society to the host in appreciation.

A Negro orchestra provided music during the meal.

Smith County Society

April 11, 1946

Smith County Medical Society met in Tyler on April 11 with twenty-two members present. M. H. Moore, vice-president, presided.

Edwin G. Faber, member of a committee appointed to study the Veterans Administration plan for medical care of veterans, discussed the program and the manner in which other states are handling the home care of ex-servicemen. Upon his recommendation, the society agreed to instruct its delegate to the House of Delegates of the State Medical Association to vote for choice of physicians by veterans and for appointment of a local authority to pass on the eligibility of veterans for treatment.

T. M. Jarmon, of the program committee; Tate Miller, Dallas, and Earl Taylor, Dallas, also spoke.

Tarrant County Society

May 3, 1946

(Reported by W. P. Higgins, Jr., Secretary)

Tarrant County Medical Society met in the Medical Arts Auditorium at Fort Worth on May 3 with twenty-nine members and two visitors present.

Ivan H. Readinger, E. E. Reeves, and Stephen W. Wilson were elected to membership upon application and M. C. Archer was elected to membership upon transfer from Dallas County.

Tribute was paid Dr. W. C. Lackey, who died April 5.

The secretary read a telegram from the Veterans Administration giving the types of physicians needed by the administration. A second communication was read by the secretary, asking that a list of physicians who participate in the Emergency Maternity and Infant Care program be furnished to the Red Cross. A motion was passed that a letter be sent to members of the society who do obstetrics and pediatrics work asking whether or not they wish to participate in the program and that the resulting list be sent to the Red Cross. It was also announced that a local Selective Service board needed a physician.

Wharton-Jackson-Matagorda-Fort Bend Counties Society

April 9, 1946

Wharton-Jackson-Matagorda-Fort Bend Counties Medical Society met with the Auxiliary for dinner April 9 at the Robert E. Lee Gymnasium, Rosenberg, as guests of the Fort Bend physicians and their wives.

At the close of dinner, the society heard R. C. L. Robertson, neuro-surgeon, and A. Hauser, neuropsychiatrist, both of Houston, while the auxiliary met at the home of Mrs. J. W. Weeks.

Wichita County Society

April 3, 1946

The Wichita County Medical Society's advisory board to the Wichita Health Unit met April 3 at the unit for a luncheon with members of the health unit staff. Care of persons not able to provide medical aid for themselves was considered at the meeting. Board members present included O. W. Wilson, chairman; Austin F. Leach, William Rosenblatt, J. R. Mast, A. W. Pierce, B. W. Dorbandt, and M. H. Glover.

Eighth, Ninth, and Tenth Districts (South Texas) Society

April 17, 1946

South Texas District Medical Society held its first postwar meeting April 17 at Brenham in the auditorium of the City Hall as guests of Washington County Medical Society. Approximately sixty were in attendance.

G. A. L. Kusch, Chapel Hill, president of Washington County Medical Society, welcomed the physicians, after which J. T. Tadlock, Dayton, president of the district society, presided. The following scientific program was presented:

Clinical Gynecological Problems—Karl J. Karnaky, Houston.
Roentgen Examination of the Digestive Tract—Curtis H. Burge, Houston.
Reflexes of Importance in Acute Cardiac Emergencies—Wallace Byrd, Wharton.
Splenectomies: A Ten-Year Study of the Cases in Houston, Texas (color motion picture)—J. R. Phillips and J. N. Bevil, Houston.
Transthoracic Resection of the Esophagus and Cardiac End of the Stomach—Howard T. Barkley, Houston.
Broncholithiasis—John H. Barrett, Houston.
The Management of Genito-Urinary Wounds During the Northern Burma Campaign—Michael K. O'Heeron, Houston.
Basic Principles and Problems in Geriatric Surgery—Louis Carp, New York, N. Y.
Skin Testing in Allergic Diseases—Homer E. Prince, Houston.
The Life of the Allergic Individual and What Can Be Done About It—Paul D. Fleming, Houston.

A friend chicken lunch was served at noon at the American Legion Hall, following which there was a discussion of the Wagner-Murray-Dingell bill. J. E. Clarke, Houston, councilor for the Ninth District, and F. J. L. Blasingame, Wharton, councilor for the Eighth District, explained the bill now under consideration and pointed out the necessity of physicians becoming familiar with pending medical legislation and of actively participating in elections of legislators and congressmen. A. E. Sweatland, Lufkin, councilor for the Tenth District, declined to discuss the subject further, indicating that Drs. Clarke

and Blasingame had covered the matter thoroughly.

Walter F. Hasskarl, Brenham, was elected president; Herbert E. Roensch, Bellville, vice-president; and George W. Waldron, re-elected secretary-treasurer.

T. O. Woolley, Orange, extended an invitation to the society to meet in Orange in April, 1947, as guests of the Orange County Medical Society. The invitation was accepted.

AUXILIARY NOTES

Officers of the Woman's Auxiliary to the State Medical Association of Texas: President, Mrs. George Turner, El Paso; President-Elect, Mrs. C. F. Ferguson, Beaumont; First Vice-President, Mrs. L. B. Windham, Tyler; Second Vice-President, Mrs. V. M. Longmire, Temple; Third Vice-President, Mrs. R. E. Clark, Memphis; Fourth Vice-President, Mrs. J. E. Hogan, Big Spring; Corresponding Secretary, Mrs. Robert F. Thompson, El Paso; Recording Secretary, Mrs. M. A. Ramsdell, San Antonio; Publicity Secretary, Mrs. J. F. Campbell, Fort Worth; Treasurer, Mrs. Guy Jones, Dallas; Parliamentarian, Mrs. Joe Nichols, Atlanta.

AUXILIARY NEWS

Bowie-Miller Counties Auxiliary met April 26 in the home of Mrs. R. R. Kirkpatrick, Texarkana. Cohostesses were Mesdames C. H. Frank, T. F. Kittrell, and Decker Smith. Mrs. Roy Baskett presided in the absence of the president, Mrs. William Hibbitts.

Mrs. J. T. Robison talked on the Wagner-Murray-Dingell bill, after which a general discussion of the subject was participated in by the members. Mrs. L. J. Kosminsky reported on the Arkansas State Auxiliary meeting in Little Rock, at which 162 members were registered for the largest attendance since the beginning of the war. Mrs. R. C. Cross gave a report on the Women's Field Army for Cancer Control, which the auxiliary approved for 100 per cent membership.

The nominating committee, composed of Mesdames Robison, E. M. Watts, and Harry Murry, proposed the following officers who were elected for the coming year: Mesdames N. B. Daniel, president; C. E. Down, president-elect; J. H. Rives, first vice-president; A. G. Lee, second vice-president; N. W. Peacock, Ashdown, Ark., third vice-president; R. C. Cross, fourth vice-president; W. H. Daubs, recording secretary; Carlton Kemp, corresponding secretary; Brooks Tate, treasurer; Allen Collom, parliamentarian; C. H. Frank, historian; Roy Baskett, publicity secretary.

Guests were invited to the dining room for pink angel food squares and punch served by Mesdames Daniel and Baskett. The house was decorated with spring flowers, with pink and green predominating in the dining room.

Galveston County Auxiliary was entertained by Texas City members at an Easter tea April 19 at the home of Mrs. F. N. Danforth, with Mesdames George T. Beller, H. A. Schmidt, T. M. Frank, C. R. Danforth, Norman Jarrell, Clarence Quinn, and G. R. Manske assisting.

Mrs. Leonard Twidwell had charge of a program featuring Mr. A. L. ter Braake, who is in charge of the tin smelting process in Texas City, in a talk on the Dutch East Indies.

Harris County Auxiliary met April 30 at the home of Mrs. F. Hartman Kilgore, Houston, to hear Mrs. W. P. Neklett review "Straight Down a Crooked Lane," by Evelyn Byrd Porter. Mrs. J. C. Youngblood was chairman for the day; Mrs. Dan W. Scott, cochairman.

Hostesses assisting Mrs. Kilgore were Mesdames J. A. Brown, Bernard Farfel, Wilton M. Fisher, Herman L. Gardner, W. G. McDeed, James P. Molloy, F. J. Slataper, S. W. Thorn, and Marshall Wallis.

Harris County Auxiliary held its installation of officers in the Varsity Room of the College Inn, Houston, on May 27, meeting for a business session followed by luncheon. Mrs. L. L. D. Tuttle was chairman for the day, assisted by Mesdames J. Peyton Barnes, A. Philo Howard, Charles R. Potts, Jacob S. Schultz, Joe D. Gandy, Thomas T. Kennerly, W. S. Red, Jr., and James J. Truitt.

Mrs. J. Griffin Heard, assisted by Mesdames Shaw McDaniel, A. M. Faris, Charles R. Nester, and R. Marion Johnson, were in charge of decorations.

Mrs. J. Charles Dickson installed the new officers, who are Mesdames Fred Y. Durrance, president; L. L. D. Tuttle, president-elect; H. J. Ehlers, first vice-president; E. T. Smith, second vice-president; R. Marion Johnson, recording secretary; John Glenn, corresponding secretary; Jacob S. Schultz, treasurer; Frank Ernst, historian; James Pittman, parliamentarian; and David Wachsman, publicity secretary.—Mrs. Granville Q. Adams, Publicity Secretary.

Harrison County Auxiliary assisted in a drive during April 1 to secure donations of blood from two hundred persons in the county. Harrison County Medical Society unanimously recommended the Marshall blood bank, which hoped to make blood plasma available to every doctor associated with the medical society for only the cost of processing. The auxiliary mailed letters urging citizens of Marshall and Harrison County to help establish the blood bank by making donations on April 30 and auxiliary members were accepting registrations of persons wishing to donate blood.

South Texas District Auxiliary met at the Hotel St. Anthony in Brenham on April 17 with Mrs. Ralph Bellamy, Daisetta, president, presiding.

Mrs. Robert A. Hasskarl, Brenham, delivered the invocation; greetings were extended by Mrs. C. E. Southern, Burton; and Mrs. F. J. L. Blasingame, Wharton, responded.

At a luncheon, Mrs. M. D. Burnett, Brenham, program chairman, presented Miss Werna Lenert in two vocal solos, accompanied by Mrs. John Giddings, and Mrs. J. J. Truitt, Houston, in a reading. After luncheon the Washington County Auxiliary entertained with coffee at the ranch of Dr. and Mrs. Waldo A. Knolle. Bluebonnets were used for decoration at both the luncheon and coffee.

Mrs. Blasingame was installed as president; and Mesdames Southern as president-elect; Jarrett E. Williams, Wharton, first vice-president; W. M. Greenwood, West Columbia, second vice-president; A. O. McCary, Freeport, third vice-president; Hasskarl, recording secretary; Harry Burr, Houston, press secretary; W. H. Bridges, Goose Creek, treasurer; and S. B. Slaughter, Freeport, parliamentarian.

BOOK NOTES

[1]**Bronchial Asthma.** By Leon Unger, B. S., M. D., F. A. C. P. Assistant Professor, Department of Medicine, Northwestern University Medical School, Chicago. Introduction by Morris Fishbein, M. D., Editor, Journal of the American Medical Association. Cloth, 724 pages. Price, $9.00. Springfield, Ill., Charles C. Thomas, Publisher, 1945.

This book probably represents the most complete work available at the present time on bronchial asthma. In his straightforward style, the author has avoided controversial points as much as possible, at the same time not failing to present various techniques and procedures.

The book is arranged in three sections, the first

[1]Reviewed by Homer E. Prince, M. D. Houston.

and largest dealing with the clinical phases of asthma. A historical review of allergy in general is followed by a detailed treatise on asthma in particular. The subject is covered, in detail, in the chapters on etiological factors, pathological aspect, symptomatology, differential and specific diagnosis, and treatment. Closing the clinical section is a chapter on the military aspects of asthma, which was probably prompted by the fact that the book was written during the war when the presence of asthma often determined rejection from military service. This chapter should be an invaluable guide to Selective Service boards and others concerned with induction of men for military duties.

Part two of the book is a rather short section dealing with the preparation of allergens, and other technical points.

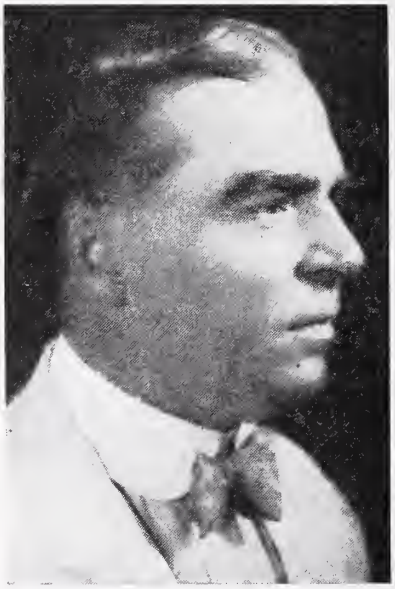
In part three (Appendix) is contained much valuable information of a general character of interest to allergic persons.

In summary, this book is well-written and reflects the author's many years of teaching the subject of allergy. It should prove useful, not only to the student and general practitioner, but should be found on the specialist's reference library shelf.

DEATHS*

Dr. Howell Houston Brown, Kingsville, Texas, died January 13, 1946, at his home of cerebral hemorrhage.

Dr. Brown was born October 10, 1879, at Coal Hill, Ark., the son of Joseph Ringold and Lucy (Houston) Brown. His early education was received in the public schools of the community. He then attended Hendrix College at Conway, Ark., and Vanderbilt University at Nashville, Tenn., from which he was graduated in medicine in 1904. He began practice in Indian Territory which later became Muskogee, Okla., in 1913 moving to San Antonio, Texas. There he did private practice and was house physician for St. Mary's Hospital. In 1927 he went to Kingsville, where he was in private practice and was chief eye, ear, nose, and throat specialist for the Missouri Pacific and Gulf Coast Lines.



DR. HOWELL HOUSTON BROWN

Almost continuously since 1919 Dr. Brown was a member of the State Medical Association and American Medical Association, first through Bexar County Medical Society and then through Kleberg-Kenedy Counties Medical Society. From 1931 until 1937 he was president of the Kleberg-Kenedy Society. He was also a member of the Texas Railway and Traumatic Surgical Association and served as health officer of Kleberg County from 1931 until December, 1944, when he became ill. He was a member of the Methodist Church and of Phi Kappa Psi fraternity.

Surviving Dr. Brown are his second wife, the former Miss Zilla Eubanks Kelly, whom he married in San Marcos on June 3, 1941; a son, Dr. L. Houston Brown, Temple; a daughter, Mrs. Janice Brown Brandt, San Antonio; a brother, Joseph R. Brown, Kansas City, Mo.; and a sister, Mrs. Dick Bruun, Fort Smith, Ark.

Dr. Charles Edward Crain, San Antonio, Texas, died of cancer of the larynx December 15, 1945, at Fitzsimmons General Hospital, Denver, Colo., while on active duty as a captain in the Army Medical Corps.

The son of Lee Thomas and Ada Florence (Nichols) Crain, Dr. Crain was born April 1, 1896, at San Antonio, where he received his preliminary education in the public schools. He attended St. Mary's University, San Antonio, and the University of Texas, Austin, obtaining his medical degree from Baylor University College of Medicine, Dallas, in 1937. He served an internship at St. Joseph's Hospital, Fort Worth, after which he practiced in San Antonio until 1942, when he was called to military service.

DR. CHARLES EDWARD CRAIN

Dr. Crain had participated in the Mexican Border campaign as a member of the Texas National Guard calvary and in World War I with the Trains and Military Police. He was among the first officers to be commissioned at old Camp Funston. When World War II began, Dr. Crain was one of the first physicians in San Antonio to be appointed to a Selective Service board, on which he served until he entered the Army. He first was appointed to the staff of the station hospital at Fort Bliss, Texas, and then went overseas with the 279th Hospital Unit in the British Isles. After more than a year there he was returned to the United States because of illness.

During most of his professional career Dr. Crain was a member of the State Medical Association and American Medical Association through Bexar County Medical Society. He was a member of the Baptist Church, Theta Kappa Psi fraternity, and a Mason.

In 1918 Dr. Crain married Miss Blanche Woods, of San Antonio, who survives. He is also survived by two sons, Capt. Charles E. Crain, Jr., Salina, Kan., and Lee T. Crain, Anchorage, Alaska; two daughters, Mrs. Blanche Crain Slaven and Mrs. Theodore J. Pedrojetti, San Antonio; his mother, Mrs. Ada N. Crain, San Antonio; three sisters, Mrs. John M. Sallee, Mrs. Arthur Byrd Youngs, and Mrs. Christie

*An obituary ordinarily will not be published more than four months after date of death. Coöperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

T. Orth, all of San Antonio; and two grand-daughters, Sugar Lee and Blanche Lois Slaven, San Antonio.

Dr. Ira F. Cannon, Mart, Texas, died at his home April 4, 1946, of cirrhosis of the liver following several months of illness.

Dr. Cannon was born August 3, 1874, in Freestone County and was reared near Thornton. He was graduated from Sam Houston Normal Institute and then attended the University of Nashville, Tenn., where he received a bachelor of science degree in 1898. He obtained his medical degree from the University of the South, Sewanee, Tenn., in 1901. He later did postgraduate work at Tulane University, New Orleans. After four years in Fannin County, Texas, Dr. Cannon moved to Wolfe City, and then, in 1906, to Mart, where he practiced until his death.

Almost continuously since 1908 Dr. Cannon was a member of the State Medical Association and American Medical Association through McLennan County Medical Society. He was also for several years and at the time of his death district surgeon for the Missouri Pacific Railroad. He was a member of the Baptist Church, the Mart Lions Club, the American Legion, and had served during World War I as a first lieutenant in the Medical Corps.

Dr. Cannon married Miss Beulah Spencer, Thornton, in December, 1901. He is survived by his wife; one son, Spencer Cannon, Waco; and two brothers, Jim Cannon, Mexia, and W. J. Cannon, Mart.

Dr. John Thomas Hairston, San Antonio, Texas, died of carcinoma in a San Antonio hospital January 24, 1946.

Dr. Hairston was born May 8, 1903, at Independence, Texas, the son of Dr. and Mrs. T. C. Hairston. He received his academic education at the University of Texas, Austin, and secured his medical degree from the University of Texas School of Medicine, Galveston, in 1928. After serving an internship at the General Hospital in Kansas City, Mo., Dr. Hairston began practicing in San Antonio in 1929, serving there until his death.

DR. JOHN THOMAS HAIRSTON

Throughout his professional life Dr. Hairston was a member of the Bexar County Medical Society, State Medical Association, and American Medical Association. He was also a member of the Southern Medical Association and a Fellow of the American College of Surgeons. He was a member of the Baptist Church, Alpha Kappa Kappa medical fraternity, Scottish Rite, and Shrine. He enjoyed fishing, hunting, and skeet shooting, and won the cup for skeet shooting at State Medical Association meetings in 1939 and 1940.

Surviving are Dr. Hairston's wife, the former Miss Lucile Walker, whom he married July 25, 1929, in Waco; a daughter, Jane Carolyn Hairston, San Antonio; a son, John Thomas Hairston, Jr., San Antonio; his parents, Dr. and Mrs. T. C. Hairston, Independence; and three sisters, Mrs. C. B. Dilworth, Austin; Miss Martha Hairston, Houston; and Miss Hazel Hairston, Waco.

Dr. Leamon Monroe Ward, Odessa, Texas, died March 8, 1946, in a local hospital of cerebral hemorrhage.

The son of Mr. and Mrs. Roy Ward, Dr. Ward was born August 17, 1917, at Coolidge. He attended Baylor University, Waco, and received his doctor of medicine degree at Baylor University College of Medicine, Dallas, in June, 1940. He served an internship at Southern Baptist Hospital, New Orleans, before entering the United States Army July 1, 1941. He served overseas from April 3, 1942, until October 30, 1944, as a captain in the Medical Corps. He was discharged from military service February 22, 1946, and had begun practice at the Wood Hospital in Odessa shortly before his death. He was a member of the Methodist Church.

DR. LEAMON MONROE WARD

Dr. Ward is survived by his wife, the former Miss Madeline Goolsby, of Wortham, whom he married June 23, 1945, and by a baby daughter, Linda Lea Ward, born April 24, 1946. Also surviving are two brothers, Jack Ward, Coolidge, and Bill Ward, Dallas, and one sister, Miss Juanita Ward, Mexia.

Dr. Joseph Leslie Hall, Stanton, Texas, died October 24, 1944, two hundred miles off the coast of China when the Japanese ship on which he was a prisoner was sunk by submarine action.

Dr. Hall was born March 20, 1913, at Stanton, the son of Mr. and Mrs. J. L. Hall. He attended Schreiner Institute, Kerrville, and Texas Technological College, Lubbock, where he received his bachelor of arts degree. He obtained his medical degree in 1938 from the University of Texas School of Medicine, Galveston. After serving an internship at the Robert B. Green Hospital, San Antonio, Dr. Hall practiced in Roscoe about a year before moving to Stanton, where he was in practice during 1940 and 1941. He entered military service in September, 1941, was taken prisoner by the Japanese upon the fall of Bataan in 1942, and remained in custody of the enemy until his death.

The bronze star medal was awarded posthumously to Dr. Hall for meritorious achievement while in military prison camp in the Philippine Islands. The citation credited Dr. Hall with exceptional service in curtailing the physical and mental deterioration which was becoming apparent among the diseased prisoners, and said in part: "By his dauntless spirit of self-sacrifice, untiring devotion to duty, and unwavering courage in the face of increasingly dis-

heartening conditions, Lieutenant Hall was instrumental in saving the lives of many comrades, and his unselfish service exemplified the highest traditions of the United States Army Medical Department."

Dr. Hall was a member of the State Medical Association and American Medical Association, first through Nolan-Fisher-Mitchell Counties Medical Society and then through Ector-Martin-Midland-Howard-Andrews-Glasscock Counties Medical Society. He served as president of the latter society in 1941. He was a member of Phi Beta Phi fraternity.

Survivors include Dr. Hall's wife, the former Miss Mary Jane Hanks, whom he married October 15, 1938, in Houston, who resides in Texarkana; his parents, Mr. and Mrs. J. L. Hall, Stanton; a sister, Mrs. James Gooch, Admire, Kan.; and a brother, Millard Hall, Stanton.

Dr. Walter Lee Jackson, Ranger, Texas, died of coronary thrombosis at his home March 13, 1946.

The son of Mr. and Mrs. Minter Jackson, Dr. Jackson was born January 17, 1889, at Healdton, Okla., but moved to Cook County, Texas, with his family when he was a small boy. He attended the rural schools near his home and Decatur Baptist College, Decatur, before being graduated from Baylor University College of Medicine, Dallas, in 1917. He served an internship at Baylor Hospital, Dallas, then known as Texas Baptist Memorial Hospital. Upon completion of his internship, Dr. Jackson entered the Army Medical Corps as a first lieutenant, serving first in this country and then eight months with Base Hospital 136 in France. In 1919 when he was released from military service, Dr. Jackson went to Ranger to practice medicine. With three other physicians in 1923 he established the Ranger Medical and Surgical Clinic. After the death of two of the physicians and the removal of the third, Dr. Jackson was joined by his brother in operation of the Ranger Clinic, with which he continued active until his death. Dr. Jackson had done postgraduate work at Washington University, St. Louis; University of Texas, Galveston; Baylor University, Dallas; and New Orleans Graduate Medical Assembly.

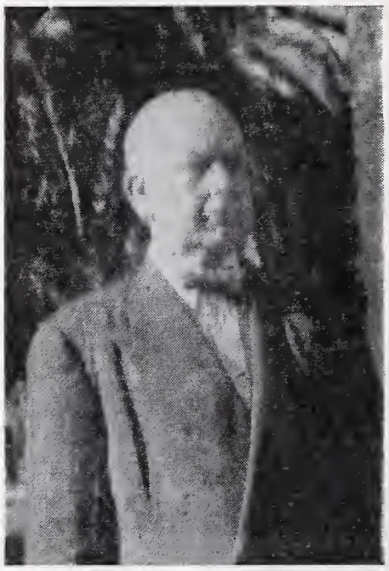
DR. WALTER LEE JACKSON

Since 1920 Dr. Jackson had been a member of the State Medical Association and American Medical Association, first through Dallas County Medical Society and then through Eastland-Callahan Medical Society. He was president of the latter organization in 1931. He was very active in church work and at the time of his death was teacher of the men's Bible class at the First Baptist Church. He was a member of the board of trustees of the Ranger public schools for fourteen years, for two of which he served as president. He was a member of the board of Ranger General Hospital, a past president of the Ranger Lions Club, a Mason, and a member of the American Legion and Veterans of Foreign Wars.

At Teague on October 20, 1920, Dr. Jackson married Miss Exa Lewis, who survives. Other survivors include three sons, S/Sgt. Walter Lee Jackson, Jr., with the Marines in China; Albert W. Jackson, SM 2-c, who has recently returned from duty in the Pacific; and Andrew Lewis Jackson, Ranger; his mother, Mrs. M. Jackson, Denton; six brothers, Dr. C. L. Jackson, Ranger; Horace Jackson, Pasadena; Homer Jackson, Irving; Frank Jackson, Pasadena; Marvin Jackson, Thalia; and Luther Jackson, Nocona; and three sisters, Mrs. John Duggan, Nocona; Mrs. Lehman Hunter, Pasadena; and Miss Alma Jackson, a missionary in Brazil.

Dr. John Gaillard Webb, Mercedes, Texas, died April 17, 1946, of malignancy of the colon.

Born November 8, 1879, at Lower Peachtree, Ala., Dr. Webb was the son of W. H. and Mary (Bumpus) Webb. He came to Texas and attended the public schools of Galveston and the University of Texas in Austin before taking his degree in medicine at the University of Texas in Galveston in 1913. He spent the next two years at St. Mary's Hospital, Galveston, and Southwestern Mental Hospital, San Antonio, and then began practice in Mercedes, where he remained until his death.



DR. JOHN G. WEBB

Throughout his professional life Dr. Webb was a member of the State Medical Association and American Medical Association, first through Bexar County Medical Society, then through Hidalgo County Medical Society, and finally, upon its organization in 1934, through Hidalgo-Starr Counties Medical Society. He was also a member of the Southwest Texas District Medical Society. Dr. Webb was elected councilor of the Sixth District of the State Medical Association in 1934 and had served competently in that capacity until his death. He was a local Missouri Pacific Railroad physician. physician for the Mercedes High School football squad, a thirty-second degree Mason, past Rotarian, and a first lieutenant in the Texas State Guard until its deactivation in December, 1945. Dr. Webb was a student of current advances in medicine and of world affairs. He enjoyed deer hunting and wood working, being an accomplished cabinet maker.

Dr. Webb married Miss Lucy Yates at La Feria on May 17, 1933. He is survived by his wife; a brother, Thurston A. Webb, Houston; and two sisters, Mrs. Albert Bailey, Houston, and Mrs. Fannie Weems, Excelsior Springs, Mo.

Upon proclamation by the mayor of Mercedes, all activity in the community ceased for two hours the afternoon of April 19 in tribute to the memory of Dr. Webb.

MEMBERSHIP

STATE MEDICAL ASSOCIATION OF TEXAS

JUNE, 1946

No. 1. El Paso District, embracing the following counties: Brewster, Culbertson, El Paso, Hudspeth, Jeff Davis, Loving, Pecos, Presidio, Reeves, Ward and Winkler.

No. 2. Big Spring District, embracing the following counties: Andrews, Borden, Dawson, Dickens, Ector, Fisher, Gaines, Garza, Glasscock, Howard, Kent, King, Lynn, Martin, Midland, Mitchell, Nolan, Scurry, Stonewall, Terry and Yoakum.

No. 3. Panhandle District, embracing the following counties: Armstrong, Bailey, Briscoe, Carson, Castro, Childress, Cochran, Cottle, Collingsworth, Crosby, Dallam, Deaf Smith, Donley, Floyd, Foard, Gray, Hale, Hall, Hansford, Hardeman, Hartley, Hemphill, Hockley, Hutchinson, Lamb, Lipscomb, Lubbock, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher and Wheeler.

No. 4. San Angelo District, embracing the following counties: Brown, Coke, Coleman, Comanche, Concho, Crane, Crockett, Irion, Kimble, Mason, Menard, Mills, McCulloch, Reagan, Runnels, San Saba, Schleicher, Sterling, Sutton, Tom Green and Upton.

No. 5. San Antonio District, embracing the following counties: Atascosa, Bandera, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Gonzales, Guadalupe, Karnes, Kendall, Kerr, Kinney, LaSalle, Maverick, Medina, Real, Terrell, Uvalde, Val Verde, Wilson and Zavala.

No. 6. Corpus Christi District, embracing the following counties: Aransas, Bee, Brooks, Cameron, Duval, Hidalgo, Jim Hogg, Jim Wells, Kenedy, Kleberg, Live Oak, McMullen, Nueces, Refugio, San Patricio, Starr, Webb, Willacy and Zapata.

No, 7, Austin District, embracing the following counties: Bastrop, Blanco, Burnet, Caldwell, Hays, Lampasas, Lee, Llano, Travis and Williamson.

No. 8. DeWitt District, embracing the following counties: Calhoun, Colorado, DeWitt, Fayette, Fort Bend, Goliad, Jackson, Lavaca, Matagorda, Victoria and Wharton.

No. 9. Southern District, embracing the following counties: Austin, Brazoria, Burleson, Galveston, Grimes, Harris, Madison, Montgomery, Polk, San Jacinto, Trinity, Waller, Walker and Washington.

No. 10. Southeastern District embracing the following counties: Angelina, Chambers, Hardin, Japer, Jefferson, Liberty, Nacogdoches, Newton, Orange, Panola, Rusk, Sabine, San Augustine, Shelby and Tyler.

No. 11. Eastern District, embracing the following counties: Anderson, Cherokee, Freestone, Henderson, Houston, Leon and Smith.

No. 12. Central District, embracing the following counties: Bell, Bosque, Brazos, Coryell, Erath, Falls, Hamilton, Hill, Hood, Johnson, Limestone, McLennan, Milam, Navarro, Robertson and Somervell.

No. 13. Northwestern District, embracing the following counties: Archer, Baylor, Callahan, Clay, Eastland, Haskell, Jack, Jones, Knox, Montague, Palo Pinto, Parker, Shackelford, Stephens, Tarrant, Taylor, Throckmorton, Wichita, Wilbarger, Wise and Young.

No. 14. Northern District, embracing the following counties: Collin, Cooke, Dallas, Delta, Denton, Ellis, Fannin, Franklin, Grayson, Hopkins, Hunt, Kaufman, Lamar, Rains, Rockwall, Van Zandt and Wood.

No, 15. Northeastern District, embracing the following counties: Bowie, Camp, Cass, Gregg, Harrison, Marion, Morris, Red River, Titus and Upshur.

FIRST OR EL PASO DISTRICT

Dr. Ralph H. Homan, El Paso, Councilor.

EL PASO COUNTY MEDICAL SOCIETY

Alexander, M. L., Canutillo.
Arguelles, F. L., El Paso.
Armistead, E. K., El Paso.
Armistead, S. D., El Paso.
Awe, Chester D., El Paso.
Barrett, Frank O., El Paso.
Belanger, Geo. L., Ysleta.
Bell, H. J., El Paso.
Bennett, J. T., El Paso.
Bernell, C. E., El Paso.
Black, Arthur P., El Paso.
Branch, W. M., El Paso.
Breck, Louis W., El Paso.
Britton, W. W., El Paso.
Brown, Chas. P., El Paso.
Brunner, Geo., El Paso.
Butler, Arthur H. (Hon.), El Paso.
Cardwell, Robt. J., El Paso.
Carter, Joe C., El Paso.
Causey, E. Grady, El Paso.
Collins, Wm. A., Jr., El Paso.
Cooley, Ben H., El Paso.
Cooper, Arlin B., El Paso.
Cox, Lyman T., El Paso.
Cuen, M. J., Ysleta.
Curtis, W. R., El Paso.
Cummins, Erwin J., El Paso.
Davis, Wm. J., El Paso.
Deady, Howard P., El Paso.
Dietrich, H. W., El Paso.
Duckett, Walter F., El Paso.
Duncan, Ernest A., El Paso.
Dutton, Loraine O., El Paso.
Eck, A. J., El Paso.
Egbert, Orville E., El Paso.
Epstein, I. M., El Paso.
Evans, F. G., El Paso.
Feener, Lester C., El Paso.
Floyd, Joel R., El Paso.
Gaddis, Leo R., El Paso.
Gaddy, S. J., El Paso.
Galatzan, Joe S., El Paso.
Gallagher, Paul, El Paso.
*Garrett, Henry D., El Paso.
Goehring, H. D., El Paso.
Goodloe, Basil L., El Paso.
Goodwin, Francis C., El Paso.
*Gorman, James J., El Paso.
Gray, John B., El Paso.
Green, J. Leighton, El Paso.
Gregory, J. M., El Paso.
Hardy, John A., El Paso.
Hart, Maynard S., El Paso.
Hatfield, H. D., El Paso.
Hendricks, C. M., El Paso.
Hinton, Jos. H., El Paso.
*Holt, Russell, Pres., El Paso.
*Homan, R. B., Jr., El Paso.
*Homan, Ralph H., El Paso.
Hornedo, Manuel D., El Paso.
Hunter, C. D., El Paso.
Hyslop, Jas. R., El Paso.
Irvin, Edgar H., El Paso.
Jamieson, W. R., El Paso.
Jenness, Burt F., El Paso.
Jones, Edmund P., El Paso.
Jumper, C. E., El Paso.
Keller, N. H., El Paso.
King, Jack A., El Paso.
King, Sam R., El Paso.
Kitterman, P. G., El Paso.
Laws, James W., El Paso.
Leigh, Harry, El Paso.
Liddell, Thos. C., El Paso.
*Long, Arthur D., El Paso.
Lombard, Julian, El Paso.
Marshall, Alex G., El Paso.
*Martin, John D., El Paso.
Mason, C. H., El Paso.
McCamant, T. J., El Paso.
McChesney, Paul E., El Paso.
McNeil, Irving, El Paso.
*Miller, Felix P., El Paso.
Molinar Z. Ramon, El Paso.
Molloy, M. S., El Paso.
Morrison, John E., El Paso.
Multhauf, A. W., El Paso.
Murray, Mildred L., El Paso.
Newman, S. H., El Paso.
Pangman, W. John, El Paso.
Peticolas, John D. (Sec'y), El Paso.
Preston, T. K., El Paso.
Price, E. D., El Paso.
Prieto, Philip M., El Paso.
Randel, Brown W. (Hon.), El Paso.
Reed, P. H., El Paso.
*Rennick, Chas. F., El Paso.
Rheinheimer, E. W., El Paso.
Rigney, Paul, El Paso.
Robbins, Jacob B., El Paso.
Rodarte, Reuben D., El Paso.
Rogde, Jacob, El Paso.
Rogers, Earl B., El Paso.
Rogers, Hugh Earl, El Paso.
Rogers, Will P., El Paso.
Rogers, S. Perry, El Paso.
Schuster, Frank P., El Paso.
Schuster, Stephen A., El Paso.
Scott, T. E., El Paso.
Shannon, Hugh M., El Paso.
Shanley, T. J. B., El Paso.
*Smith, Leslie M., El Paso.
Snidow, Francis A., El Paso.
Soto, Raul C., El Paso.
Souda, Andrew, El Paso.
Spearman, M. P., El Paso.
Spier, Erich, El Paso.
Stapp, Celso C., El Paso.
Stevens, B. F., El Paso.
Stevenson, Walter H., El Paso.
*Stowe, Jesson L., El Paso.
Swope, Samuel D. (Hon.), El Paso.
Thompson, Ernest B., El Paso.
Thompson, Robt. F., El Paso.
Treece, Angus A., Fabens.
Tubbs, Wm. M., El Paso.
Tucker, Geo. E., Anthony, N. Mex.
*Turner, George, El Paso.
Turner, Steve F., El Paso.
Vance, James, El Paso.
Vandevere, W. E., El Paso.
Vargas-Gonzalez, F., El Paso.
Varner, Harry H., El Paso.
Villareal, Andres, El Paso.
Villareal, Leopold, El Paso.
Vinikoff, Maurice R., El Paso.
Von Almen, S. G., El Paso.
Von Briesen, Delphin, El Paso.
Waite, W. W. (Hon.), El Paso.
Walker, Newton F., El Paso.
Webb, Chas. E., El Paso.
*Wilcox, Leigh E., El Paso.

PECOS-JEFF DAVIS-PRESIDIO-BREWSTER COUNTIES MEDICAL SOCIETY

Barrett, Alfred E., Ft. Stockton.
Craddock, Walter D., Fort Stockton.
Gipson, J. F., Ft. Stockton.
Hill, Malone V., Alpine.
Jeter, Drayton O., Alpine.
Kelley, W. N., Terlingua.
Lavanture, L. A., Marfa.

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*The asterisk (*) indicates registration at the Galveston annual session.
(In.) indicates Intern membership.
(Hon.) indicates Honorary membership.
(Emer.) indicates Membership Emeritus.
(Mil.) indicates Military membership.

Lockhart, W. E. (Pres.), Alpine.
Pate, Jno. W., Sanderson.
Searls, Jno. P., Marfa.
Sutton, C. R., Jr., Marfa.
Wright, Joel E. (Sec'y), Alpine.

REEVES-WARD-WINKLER-LOVING-CULBERSON-HUDSPETH COUNTIES MEDICAL SOCIETY

Bell, Darrell L., Monahans.
Black, Wilmer D., Barstow.
Camp, Jim (Pres.), Pecos.
Cole, C. M., Pecos.
Hanes, Lisburn C., Jr., Wink.
Kunstadt, Paul, Monahans.
Lindley, Harold, Pecos.
McClure, Wayne H., Kermit.
Munk, Otto, Monahans.
Rehmeyer, Walter O., Monahans.
Roberts, Rufus A. (Sec'y), Pecos.
Robinson, Cecil A., Kermit.
Robinson, Lila Rose, Kermit.
Wight, B. A. (Mil.), Kermit.
Wilson, Claude E., Odessa.

SECOND OR BIG SPRING DISTRICT

Dr. A. H. Fortner, Sweetwater, Councilor

DAWSON-LYNN-TERRY-GAINES-YOAKUM COUNTIES MEDICAL SOCIETY

*Bradford, Andrew L., Seagraves.
Daniell, A. H., (Sec'y), Brownfield.
Davis, Julian W., Seminole.
Frazier, Sam Z. (Pres.), Lamesa.
Hill, Wayne C., Brownfield.
Jacobson, M. E. (Mil.), Amarillo.
Johnson, J. E., Lamesa.
Loveless, J. C., Lamesa.
*Miller, Frank P., Brownfield.
Mitchell, H. C. (Mil.), Hines, Ill.
Price, Noble H., Lamesa.
Prohl, Emil H., Tahoka.
Richards, L. D., Seminole.
Sinclair, James W., Tahoka.
Smith, Alfred H., Lamesa.
Standifer, Lilburn E., Lamesa.
Tomb, Andrew S., Seminole.
Treadway, T. L., Brownfield.
Zee, Urban H., Lamesa.

ECTOR-MIDLAND-MARTIN-HOWARD-ANDREWS-GLASSCOCK COUNTIES MEDICAL SOCIETY

Absher, Lee Alton, Midland.
Bargainier, Jno. H., Galveston.
Beadles, Robt. O. (Mil.), Big Spring.
Bennett, Marion H., Big Spring.
Bobo, Thos. C., Midland.
Briggs, Harry A., Midland.
Britt, Chas. S., Midland.
*Brumage, Wm. S., Austin.
Chapple, Jas. H., Midland.
Collins, Tip M., Big Spring.
*Cooper, Andrew J., Midland.
Cowper, Roscoe B. G., Big Spring.
Curtis, Ward C., Big Spring.
Devereaux, Jas. W., Midland.
Dickerson, Melford S., Midland.
Friedwald, Vincent E., Big Spring.
Golliday, Robt. M., Midland.
Haley, Jas. F. (Hon.), Midland.
*Hall, Granville T., Big Spring.
Haynes, Henry M., Jr., Odessa.
Hogan, Jno. E., Big Spring.
*Howser, Jno. P., Big Spring.
Johnson, Homer B., Midland.
*Leggett, Lloyd W., Midland.
Malone, Phocian W., Big Spring.
Miller, Garnett, Big Spring.
Patton, Doyle L., Midland.
Sanders, Jack V., Stanton.
Sanders, Nell White, Stanton
Sanders, Preston R., Big Spring.
Shaw, Chester A., Dallas.
Strauss, Edward H. (Sec'y), Big Spring.
*Thomas, Clyde E., Jr., Big Spring.
True, Geo. S. (Hon.), Big Spring.
Thomas, Jno. B., Midland.
Whitehouse, Wm. G., Midland.
Williamson. Thos. J., Big Spring.
Wood, Jno. K., Odessa.
Wood, Geo. H., Big Spring.
Woodall, Jack M. (Pres.), Big Spring.

NOLAN-FISHER-MITCHELL COUNTIES MEDICAL SOCIETY

Barb, Thos. J. (Sec'y), Roby.
Callan, Chester U., Rotan.
Crymes, J. Melvin, Colorado.
Fortner, Amos H., Sweetwater.
Johnson, Bruce H., Loraine.
Johnson, Dale F., Loraine.
Johnson, J. Frank, Rotan.
Kalvin, Henry M., Brooklyn, N. Y.
Loeb, Sam A., Sweetwater.
Logsdon, Harry A., Colorado.
Peavy, J. E., Sweetwater.
*Peters, Roland O., Sweetwater.
P'Pool, Wm. F., Sweetwater.
Price, Robert L., Sweetwater.
Richardson, James K., Sweetwater.
Rosebrough, Chas. A. (Pres.), Sweetwater.
Rudd, Laurence H., Colorado.
Supowit, S., Sweetwater.
Wilkinson, Robt. T., Rotan.
Young, James W., Roscoe.
*Young, Tom D., Roscoe.

SCURRY-DICKENS-KENT-GARZA-BORDEN-KING-STONEWALL COUNTIES MEDICAL SOCIETY

*Cockrell, C. R., Snyder.
Johnson, Robt. H., Snyder.
Nichols, Pike C., Spur.
Rosser, H. E. (Sec'y), Snyder.

THIRD OR PANHANDLE DISTRICT

Dr. E. A. Rowley, Amarillo, Councilor.

ARMSTRONG-DONLEY-CHILDRESS-COLLINGSWORTH-HALL COUNTIES MEDICAL SOCIETY

Bubblis, Jno. L., Salt Lake City.
Carriker, Fred H., Childress.
Carroll, Wm. A., Claude.
Clark, R. Ernest, Memphis.
Fox, Grover C., Childress.
Garner, J. E., Turkey.
Goodall, O. R., Memphis.
Jenkins, B. L. (Hon.), Clarendon.
Jenkins, Oscar L. (Hon.), Dallas.
Jernigan, Jas. H., Childress.
Jeter, Perry R. (Sec'y), Childress.
Jones, Chas. B., Wellington.
*Jones, Elmer W., Wellington.
Jones, Elmer K., Wellington.
Miller, Chas. H., Dallas.
Moss, E. W. (Hon.), Pharr.
Odom, Jas. A., Memphis.
Post, Geo. W., Clarendon.
Townsend, Shell H. (Pres.), Childress.
Vardy, P. L., Estelline.
Wattam, James M., Wellington.
White, F. A., Childress.

DALLAM-HARTLEY-SHERMAN-MOORE COUNTIES MEDICAL SOCIETIES

Boswell, Leta N., Stratford.
Brown, Thomas G. (Pres.), Dumas.
Cowin, Abraham W. (Sec'y), Dalhart.
Moore, Victor R., Dalhart.
Norvell, John W. (Hon.), Stratford.
Reid, Frank I., Dumas.
Richardson, Oswald J., Dumas.

GRAY-WHEELER COUNTY MEDICAL SOCIETY

Beach, Wm. Walter, San Antonio.
*Bellamy, R. M. (Pres.), Pampa.
Brown, Richard M., Pampa.
Christian, Paul C., Pampa.
Falkenstein, Richard D., Pampa.
Finley, H. Webb, McLean.
Gooch, Jas. W., Shamrock.
High, Clifton E., Pampa.
Houze, Jo W., Pampa.
Huff, Oscar, Pampa.
Jones, W. Calvin, Pampa.
Kelley, John H., Pampa.
Kelley, Frank W., Pampa.
Key, Julian M., Pampa.
*Nicholson, Harold E., Wheeler.
Overton, M. C., Jr., Pampa.
Pieratt, Karl W., Pampa.
*Purviance, Walter (Sec'y), Pampa.
Walker, Glenn R., Wheeler.
Webb, Roy A., Pampa.
Wilder, H. Lawler, Pampa.

HALE-FLOYD-BRISCOE-SWISHER COUNTIES MEDICAL SOCIETY

Dye, Everett L., Jr., Plainview.
Dye, Mary R., Plainview.
Hansen, J. Harvey, Plainview.
Jones, Don P., Plainview.
Nichols, Everett O., Sr., Plainview.
Nichols, Everett O., Jr., Plainview.
Pitts, Donald H., Floydada.
Smith, Geo. V. (Pres.), Floydada.
Smith, Edwin W., Plainview.
Stewart, Evans P., Tulia.
Wagner, Gerald W., Plainview.
Wayland, Levi C. (Sec'y), Plainview.

HANSFORD-HEMPHILL-LIPSCOMB-ROBERTS-OCHILTREE COUNTIES MEDICAL SOCIETY

Davis, J. J., Higgins.
Gower, Jos. E., Spearman.
Kengle, Geo. L., Perryton.
Morris, Ernest H. (Pres.), Canadian.
Pearson, D. B., Jr. (Sec'y), Perryton.
Sanford, Herbert M., Perryton.
Sanford, Roy K., Perryton.
Snyder, Edward H., Canadian.

HARDEMAN-COTTLE-FOARD-MOTLEY COUNTIES MEDICAL SOCIETY

*Clark, Hines, Crowell.
Edmondson, Edward E., Amarillo.
Frizzell, Thomas D., Quanah.
George, Joseph M., Quanah.
Hill, Jesse M., Crowell.
Hughes, John F. (Sec'y), Spur.
*McDaniel, Robert R., Quanah.
Pate, Clarence C., Paducah.
Salkeld, Phil L., Quanah.
*Stanley, James S., Matador.
Stover, J. E., Truscott.
*Traweek, Albert C., Sr., Matador.
Traweek, Albert C., Jr., Matador.
Vestal, Earl A. (Pres.), Quanah.

HUTCHINSON-CARSON COUNTIES MEDICAL SOCIETY

Barksdale, Wm. C., Borger.
Bivings, Chas. K., Borger.
Brooks, Wm. W., Phillips.
Draper, Leonidus M. (Mil.), Borger.
Hamra, Henry M. (Sec'y), Borger.
Hansen, Arthur F., Borger.
Hansen, Lawrence C., Borger.
Kimball, Melvin C. (Pres.), Borger.
Morris, Isaac C., Borger.
*Petty, Lester E., Borger.
Smith, Willard H., Phillips.
Stephens, Milton M., Borger.
Stephens, Walton G., Borger.

LAMB-BAILEY-HOCKLEY-COCHRAN COUNTIES MEDICAL SOCIETY

Coen, James R., Littlefield.
*Dupre, J. D. (Sec'y), Levelland.
Green, L. T., Jr., Muleshoe.
Green, M. F., Muleshoe.
Janes, Fred W., Jr., Littlefield.
Lusk, H. N., Levelland.
Payne, C. E., Littlefield.
Phillips, C. M. (Pres.), Levelland.
*Shotwell, I. T., Jr., Littlefield.
Still, O. W., Littlefield.
Williams, Edward S., Levelland.

LUBBOCK-CROSBY COUNTIES MEDICAL SOCIETY

*Arnett, Sam C., Jr., Lubbock.
*Barsh, Albert G. (Pres.), Lubbock.
Batson, Carey B., Lubbock.
Baugh, Wm. L., Lubbock.
Benson, Martin H. (Sec'y), Lubbock.
Blake, Emerson M., Lubbock.
Canon, Robert T., Lubbock.
Clark, Doyce M., Lubbock.
Cross, Denzil D., Lubbock.
Donaldson, J. D. (Mil.), Lubbock.
Douglas, R. C., Lubbock.
*Dunn, Sam G., Lubbock.
Elkins, Clyde F., Jr., Lubbock.
English, Otis W., Lubbock.
Ewing, Mahon M., Lubbock.
Fiel, Charles A., Lubbock.
Girdner. Wm. H., Abernathy.
Hand, Orra R., Lubbock.
Haney, Edward L., Ralls.
Harris, Joseph R., Jr., Lubbock.
Hunt, Ewell L., Lubbock.
*Hutchinson, Ben B., Lubbock.
Hutchinson, Jas. T., Lubbock.
Jenkins, Byron A., Lubbock.
*Kahler, Glenn E., Post.
Key, Olan, Lubbock.
*Knight, Beatrice Payne, Slaton.
*Krueger, Julius T., Lubbock.
Loveless, Jas. E., Slaton.
Loveless, Roy G., Lubbock.

Malone, Frank B., Lubbock.
Mansell, Christopher C., Lubbock.
Mast, Clarence S., Lubbock.
Mast, Henrie E., Lubbock.
McCarty, Robt. H., Lubbock.
McGuire, Scott T., Ralls.
McSween, Mangus J., Slaton.
Miller, Pauline A., Lubbock.
Overton, Marvin C., Lubbock.
Payne, Wm. E., Slaton.
Riddle, Roy L. (Mil.), Lubbock.
Rollo, Jas. W., Lubbock.
Roundtree, J. B., Lubbock.
Standefer, Fred W., Lubbock.
*Stewart, Allen T., Lubbock.
Stiles, Jas. H., Lubbock.
Surman, Arnold C., Post.
Wagner, Charles J., Lubbock.
Watkins, Mina D., Lubbock.
Williams, David C., Post.
Woods, Lemmie B., Lubbock.

POTTER COUNTY MEDICAL SOCIETY

Althaus, Jno. W. A. (Mil.), Amarillo.
Aronson, Samuel J. R., Amarillo.
Askew, Wm. L., Amarillo.
Black, R. P. (Mil.), Amarillo.
Blackwell, Ben T., Amarillo.
Broyles, Sam K., Amarillo.
Carroll, Jas. Ralph (Mil.), Amarillo.
*Churchill, Thos. P., Amarillo.
*Crume, Jno. Jas., Amarillo.
Crumley, Frederick J., Amarillo.
Cultra, Geo. M., Amarillo.
Dine, Wm. Clay (Mil.), Amarillo.
Dowling, Urban J., Amarillo.
*Duncan, Frank Benbow, Amarillo.
Duncan, Robt. A., Amarillo.
Flamm, Kenneth R., Amarillo.
*Fuller, Martin L., Mineral Wells.
Garre, Peter R., Amarillo.
Gilkerson, Nan L., Amarillo.
Gist, Robt. Dennis, Amarillo.
Goldston, Alton B., Amarillo.
Gustin, Jas. W. (Mil.), Amarillo.
Haugen, Ingvald J., Ada, Okla.
*Hendrick, Jas. W., Baltimore, Md.
Johnson, Jeremiah B., Amarillo.
Jordaan, J. D., Amarillo.
Keys, Richard, Amarillo.
Klingensmith, Wm. R., Amarillo.
Knight, Melvin K. (Mil.), Amarillo.
Latson, Harvey H., Amarillo.
*Lemmon, Jefferson R., Amarillo.
Loving, Dan H., Amarillo.
Marclay, David M., Amarillo.
Marsalis, Don S., Amarillo.
Murphy, Weldon O., Amarillo.
Owens, Guy, Amarillo.
Ozier, Jas. B. (Hon.), Amarillo.
Patton, David M., Amarillo.
Patton, Louis K., Amarillo.
Payne, Ralph B., Amarillo.
Potter, Wilkes Armstrong, Amarillo.
Powers, Evelyn G., Amarillo.
Powers, Geo. L., Amarillo.
Prince, Norman C., Amarilo.
Puckett, Bascom M., Amarillo.
Puckett, Howard E. (Mil.), Amarillo.
Rasco, Isaac, Amarillo.
Roach, D. (Hon.), Amarillo.
Robberson, Jason H., Amarillo.
*Rowley, Elmer A., Amarillo.
Royse, Geo. T., Amarillo.
Russell, Woolworth, Amarillo.
Shudde, Wm. J. (Mil.), Amarillo.
Smith, G. Ernestine, Amarillo.
*Streit, August J., Amarillo.
Swindell, Raymond R. (Pres.), Amarillo.
Thomas, Wm. B., Jr., Amarillo.
VanSwearingen, Walter, Amarillo.
Vaughn, Jno. H., Amarillo.
Vineyard, Roy L., Amarillo.
*Vinyard, Geo. T., Amarillo.
Waddill, Geo. M. Jr. (Sec'y), Amarillo.
Wertz, Royall F., Amarillo.
Wheir, Wm. Hugh (Mil.), Amarillo.
White, Jesse B., Amarillo.
*Winsett, Amos E., Amarillo.
Wrather, Jas. R., Amarillo.
Wyatt, Malcolm H., Amarillo.

RANDALL-DEAF SMITH-PARMER-CASTRO-OLDHAM COUNTIES MEDICAL SOCIETY

Cogswell, R. E. (Sec'y), Dimmitt.
Donnell, Chas. E., Canyon.
Jarrett, Robt. P., Canyon.
Loyd, Oscar H., Vega.
Miller, Mayes, Dimmitt.
Neblett, Robt. A., Canyon.
Robinson, Dutch, Rocksprings.

FOURTH OR SAN ANGELO DISTRICT

Dr. O. N. Mayo, Brownwood, Councilor.

BROWN-COMANCHE-MILLS-SAN SABA COUNTIES MEDICAL SOCIETY

*Allen, Homer B. (Pres.), Brownwood.
Allen, Will L., Brownwood.
*Bullard, Chester C., Brownwood.
Burns, Edward J., Bangs.
Cadenhead, Ernest F., Brownwood.
*Campbell, Jas. M., Goldthwaite.
Carrigan, Thos. A., Brownwood.
Gold, Philip S., Brownwood.
Gray, Chas. W., Comanche.
Hallum, Roy G., Brownwood.
Horn, Jesse M., Brownwood.
Hughes, Sidney W., Brownwood.
Lobstein, Henry L., Brownwood.
*Locker, Harry L., Brownwood.
*Mayo, Oscar N., Brownwood.
McDaniel, Horace M., May.
McFarlane, Joe R. (Sec'y), Brownwood.
Pence, Winfield S., San Saba.
Pierce, Ethel M., Brownwood.
Pope, Fielding M., Brownwood.
Scott, David R., Brownwood.
Shelton, Ben M., Brownwood.
Walker, Jas. B. N., Brownwood.
Wheelis, Paul M., Brownwood.

COLEMAN COUNTY MEDICAL SOCIETY

Aston, Samuel N., Coleman.
Burke, Francis M., Coleman.
Cochran, Robt. H., Coleman.
Lovelady, Roy R. (Pres.), Santa Anna.
*McDonald, Earl D., Santa Anna.
Moody, Chas. O. (Sec'y), Coleman.
Nichols, Jno. M., Coleman.
Weaver, Manly E., Coleman.
Young, J. C., Coleman.

CRANE-UPTON-REAGAN COUNTIES MEDICAL SOCIETY

Agnew, Wm. W., Texon.
Birdsong, W. F., Amherst.
Bredehoft, J. C. (Pres.), Rankin.
Cooper, Jas. L., McCamey.
Cooper, W. H. (Sec'y), McCamey.
*Pattison, J. F., Big Lake.
Robinson, S. F., Crane.

KIMBLE-MASON-MENARD-McCULLOCH COUNTIES MEDICAL SOCIETY

Alcorn, Robt. S., Menard.
Anderson, Jas. P. (Sec'y), Brady.
Anderson, Jas. S., Brady.
Baze, P. A., Mason.
Granville, J. B., Brady.
Hays, Aaron R., Brady.
Hinchman, A. W., Brady.
*Jordan, Dowell W., Brady.
Land, W. N., Lohn.
McCall, John G., Brady.
McCollum, Floyd L. (Pres.), Mason.
McCollum, Granville G., Mason.
Moss, E. Bruce, Junction.
Ricks, Glenn H., Brady.

RUNNELS COUNTY MEDICAL SOCIETY

*Bailey, Chas. F. (Sec'y), Ballinger.
Barron, John L., Winters.
Chandler, Oren H., Ballinger.
Cohen, Herman S., Ballinger.
*Dixon, J. W. (Pres.), Winters.
Douglas, Jas. G. (Hon.), Ballinger.
Hale, Frank M., Ballinger.
Jennings, T. V., Winters.
Lasater, O. R., Ballinger.
Rives, C. T., Jr., Winters.
Shiller, John J., Rowena.

TOM GREEN-COKE-CROCKETT-CONCHO-IRION-STERLING-SUTTON-SCHLEICHER COUNTIES MEDICAL SOCIETY

Anderson, Hiram M. (Mil.), San Angelo.
Anderson, Wilson D., San Angelo.
Arledge, Robt. M. (Mil.), San Angelo.
Barnard, Richard C., Sanatorium.
Brask, Kermit, San Angelo.
Brown, Brian T. (Mil.), San Angelo.
Bunyard, Jos. A., San Angelo.
Bush, Wm. L. (Mil.), San Angelo.
*Butner, W. B., San Angelo.
*Byars, Perry J. C., Jr., San Angelo.
Carbrey, Thos. E., San Angelo.
Cobb, Walton W. (Hon.), Fort Worth.
Cooper, Betty (In.), Philadelphia, Pa.
Doss, Jas. M., Hollywood, Calif.
Everett, W. B. (Hon.), Fostoria.
Finks, Robt. M. (Sec'y), San Angelo.
Fowler, David D. (Hon.), Paint Rock.
French, Cecil M., San Angelo.
Griffith, J. K. (Hon.), Robert Lee.
Helbing, Arlington, Barnhart.
Hess, David L., San Angelo.
Hickman, H. E., San Angelo.
Hixson, Jesse S. (Hon.) San Angelo.
Hixson, Wm. C., San Angelo.
Howell, Jno F., Sonora.
Hutchins, F. Leon, San Angelo.
Johnston, Calvin R., San Angelo.
Kunath, Carl A., San Angelo.
Lewis, Aubrey L., San Angelo.
Madding, Gordon F., San Angelo.
Mays, Chas. E. (Hon.), San Angelo.
McAnulty, Jas. P., San Angelo.
McGee, Aubrey S. (Mil.), San Angelo.
McIntire, Floyd T., San Angelo.
*McKnight, Jos. B., Sanatorium.
Mee, Edmond L., San Angelo.
Mitchell, W. Grady (Pres.), San Angelo.
Nesrsta, Geo. L., San Angelo.
Nibling, Geo. W., San Angelo.
Oakes, Milton C. (Mil.), San Angelo.
Powers, Rufus L., San Angelo.
Rape, J. Marvin, San Angelo.
Roberts, Wm. B., San Angelo.
Round, Kyle B., San Angelo.
Samuel, Hewell C., Sanatorium.
Schulkey, Wm. Earl, San Angelo.
*Schulze, Victor E., San Angelo.
Sessums, Jno. R. (Hon.), San Angelo.
Sessums, Jno. Valton (Mil.), San Angelo.
Sheckles, Loyd W. (Mil.), San Angelo.
Shelton, Joel (Mil.), Sonora.
Smith, Jerome H., San Angelo.
Smith, Wm. Lacy, San Angelo.
Swann, Wm. J., Sterling City.
*Tandy, Hugh B., Ozona.
Tester, Lewis K. (Mil.), San Angelo.
Wall, D. D. (Mil.), San Angelo.
*Windham, Robt. E., San Angelo.
*Womack, Clifford T., San Angelo.
Wood, Murray, San Angelo.
Woodward, Lewis O., San Angelo.
Yates, G. Marion (Hon.), San Angelo.

FIFTH OR SAN ANTONIO DISTRICT

Dr. C. E. Scull, San Antonio, Councilor.

ATASCOSA COUNTY MEDICAL SOCIETY

Irwin, C. M., Charlotte.
*Joyce, Walter H. (Pres.), Lytle.
Mann, Robert E., Pleasanton.
Ogden, U. B. (Sec'y), Pleasanton.
Payne, J. H., Jourdanton.
Ward, Jeremiah, Jr., Poteet.
Ware, T. P., Poteet.
Youngblood, R. C., Pleasanton.

BEXAR COUNTY MEDICAL SOCIETY

Adelman, Jack A., San Antonio.
*Aderhold, James P., San Antonio.
*Alexander, C. B., San Antonio.
Allen, S. W., San Antonio.
Allin, Fred A., San Antonio.
Allin, Willis W., San Antonio.
Altgelt, Daniel D., San Antonio.
Alvis, Milton E., San Antonio.
Anderson, James L., San Antonio.
Arendt, E. J., San Antonio.
Atkinson, Donald T., San Antonio.
Atmar, R. C., San Antonio.
Barbato, Lewis (Mil.), San Antonio.
Barton, Julian C., San Antonio.
Bates, Leroy E., San Antonio.
Beach, Asa, San Antonio.
Beal, Albert R., San Antonio.
Beck, Emma, San Antonio.
Bell, Wheeler (Mil.), San Antonio.
Berchelmann, Adolphus, San Antonio.
Bergfeld, Jack A. (Mil.), New Braunfels.
Bernfield, Helen-Canon, San Antonio.
Bernfield, Martin A., San Antonio.
Biggar, Jas. H., San Antonio.
Blair, William F., San Antonio.
Bloom, Bernard H., San Antonio.
Boccelato, S. L., San Antonio.
Boehs, Charles J., San Antonio.
Bondurant, W. W., Jr., San Antonio.
Bonnet, Edith M., San Antonio.
Bose, Edda von, San Antonio.
Boso, Fred M., San Antonio.
Bosshardt, Carl E., San Antonio.
Bounds, Jos. B., San Antonio.

Bowen, P. G., San Antonio.
Bowen, R. E., Sr., San Antonio.
Bowen, Robt. E., Jr. (Mil.), San Antonio.
*Boyd, G. D., San Antonio.
Boyd, Ina, San Antonio.
Boysen, Arthur E., San Antonio.
Breuer, Alfred, San Antonio.
Bronson, A. Scott, San Antonio.
Brown, Alexander A., San Antonio.
Brown, Louis R., San Antonio.
Brunner, Geo. H., San Antonio.
Brunner, Robbie Neeley, San Antonio.
Burg, Edward M., San Antonio.
Burk, W. E., San Antonio.
*Burleson, John H., San Antonio.
Bush, Howard M., San Antonio.
Butler, Thos. B., San Antonio.
Buttery, Harold D., San Antonio.
Cade, Charles C., San Antonio.
Cade, Wm. H., San Antonio.
Calder, Royall M., San Antonio.
Callan, John R., San Antonio.
Calvert, Hulon E., San Antonio.
Carnahan, Robt. G., Denver, Colo.
Carter, James W., Jr., Galveston.
Case, John B., San Antonio.
Cassity, J. C., San Antonio.
Cayo, Edward A., San Antonio.
Cayo, E. P., San Antonio.
*Celaya, Henry, San Antonio
Center, Wm. M. (Mil.), San Antonio.
Champion, A. N., San Antonio.
Chankin, Edgar D., San Antonio.
Cherry, Robt. L., Bolivia, South Am.
Childers, M. A., San Antonio.
Christian, Thomas E., San Antonio.
*Clark, A. Fletcher, San Antonio.
Clark, A. F., Jr. (Mil.), San Antonio.
Clark, James W. (Mil.), San Antonio.
Clayton, Bonnar M., San Antonio.
Clifton, Collis B., San Antonio.
*Coates, Elmer T., San Antonio.
*Cochran, J. L. (Sec'y), San Antonio.
Cook, Clara G., San Antonio.
*Cooper, Elmer E., San Antonio.
Cooper, Fred B., San Antonio.
Cooper, Jean Head, San Antonio.
Cooper, Melbourne J., San Antonio.
*Copeland, Jos. B., San Antonio.
Cornick, George B., San Angelo.
Cotham, C. M., San Antonio.
*Cowles, Andrew G., San Antonio.
*Coyle, Edward W., San Antonio.
Craig, Chas. F. (Hon.), San Antonio.
Crockett, R. H., San Antonio.
Culli, George O., San Antonio.
Cutter, Irving T., San Antonio.
Davis, Milton, San Antonio.
Davis, Raleigh L., San Antonio.
Delagoa, A. C., San Antonio.
DeLeon, John J., San Antonio.
DePew, E. V., San Antonio.
*Dittman, Charles H., San Antonio.
Donaldson, J. M., San Antonio.
Donop, Perry T., San Antonio.
Dorbandt, Moss M., San Antonio.
Dorbandt, Thomas M., San Antonio.
Dreibordt, Ben A., San Antonio.
*Dreiss, A. M., San Antonio.
Dufner, Romie M., San Antonio.
Dumas, Edward D., San Antonio.
Edwards, Douglas, San Antonio.
Ellis, Sam, San Antonio.
Fein, Bernard T., San Antonio.
Fetzer, William J., San Antonio.
Fischer, Albert, San Antonio.
Fisher, Rowan E., San Antonio.
Folbre, Thos. W. (Mil.), San Antonio.
Forbes, M. A., San Antonio.
*Ford, Walter L., Ft. Sam Houston.
France, Gerald D., San Antonio.
Franke, Winthrop I., San Antonio.
French, Jack A., San Antonio.
French, Sanford W., San Antonio.
Fultz, B. Hugh, San Antonio.
Galloway, B. E., San Antonio.
Garnett, Walter L., Mexico City, Mex.
Garren, John T. (Mil.), Turnersville.
Geissler, Wallace H., San Antonio.
Gerodetti, O. F., San Antonio.
Geyer, George H., San Antonio.
Giesecke, Carl G., San Antonio.
*Giles, Roy G., San Antonio.
Gill, James P., San Antonio.
*Gill, William D., San Antonio.
Glober, Lee J., San Antonio.
Goeth, Carl F., San Antonio.
Goeth, Richard A., San Antonio.
Goetz, Jos. T., San Antonio.
Gonzales, H. N., San Antonio.
*Goode, John W., San Antonio.
Goodpasture, John E., San Antonio.
Goodson, Thomas N., San Antonio.
Gordon, Marie D., San Antonio.
Gossett, Robt. F., San Antonio.
Graves, Amos Maverick, San Antonio.
Graves, W. E., San Antonio.
Haggard, Charles H., San Antonio.
*Haggard, Frank N., San Antonio.
Hargis, W. Huard, Jr., San Antonio.
Hargis, W. Huard, Sr., San Antonio.
Harper, Mary C. (Hon.), San Antonio.
Hartman, Albert W., Jr., San Antonio.
Hartman, Henry C., San Antonio.
Heck, Wm. H., San Antonio.
Heger, Frank F., San Antonio.
*Helfer, Lewis M., San Antonio.
Henning, Garold G., San Antonio.
Henry, C. D., San Antonio.
Henry, Mary M., San Antonio.
Herff, Adolph, Boerne.
*Herff, Augustus F., San Antonio.
Herff, Ferdinand P., San Antonio.
Herff, John B., San Antonio.
Herndon, Gilbert Cole, San Antonio.
*Hill, Alfred H., San Antonio.
*Hill, W. Herbert, San Antonio.
Hill, Lucius D., Jr., San Antonio.
Holshouser, Chas. A., San Antonio.
*Horton, George W., San Antonio.
*Hoskins, Henry R., San Antonio.
Howerton, Ernest E., San Antonio.
Hudson, G. W. (Mil.), San Antonio.
*Hunt, Kent N., San Antonio.
*Jackson, Dudley, San Antonio.
*Jackson, L. B., San Antonio.
Jackson, L. Walford, San Antonio.
Jackson, Martha Beal, San Antonio.
Jensen, Martin Hans, San Antonio.
Jensen, Andrew M. (Mil.), San Antonio.
Johnson, Harry McC., San Antonio.
*Johnson, Max E., San Antonio.
Johnson, Ted, San Antonio.
*Johnson, W. J., San Antonio.
Jones, L. Bonham, San Antonio.
Judkins, O. H., San Antonio.
Kahn, I. Stanley, San Antonio.
*Kaliski, Sidney R., San Antonio.
Kass, Albert, San Antonio.
Kasten, Leona, San Antonio.
Keating, Peter M., San Antonio.
Kellam, Seth W., San Antonio.
Kelley, Cole, San Antonio.
Kenney, Nat M., San Antonio.
*King, Albert C., San Antonio.
*King, W. A., Pandora.
Kitowski, C. B., San Antonio.
Kliefoth, F. H., San Antonio.
*Koch, Alvis A., San Antonio.
Koerth, Charles J., Junction.
Kopecky, Joseph, San Antonio.
Kopecky, Leon C., San Antonio.
Kost, Louis B., San Antonio.
*Kupper, Roland C. (Mil.), San Antonio.
Ladd, Graham B., San Antonio.
Lampe, Juliet H., San Antonio.
Lampe, Margaret R., San Antonio.
*Lehmann, C. Ferd, San Antonio.
Leopold, Henry N., San Antonio.
Livingston, C. S. (Mil.), San Antonio.
Lochte, E. R., San Antonio.
Lowry, S. T., San Antonio.
Lozano, Rafael, San Antonio.
*Luedemann, Waldo S., San Antonio.
Lundgren, Rupert W., San Antonio.
Lyon, Ervin F., Jr., San Antonio.
Magrish, Philip, San Antonio.
*Manhoff, Chas. M., San Antonio.
*Manhoff, Louis J., San Antonio.
Martin, Frank M., San Antonio.
Martinez, Jos. J., San Antonio.
Matthaei, Pearl V., San Antonio.
Matthews, J. D. F., San Antonio.
*Matthews, John L., San Antonio.
Maxwell, Ernest A., New York, N. Y.
Maxwell, W. Wortham, San Antonio.
May, Lester M., San Antonio.
Mayes, Lee Page, San Antonio.
McComb, Asher R., San Antonio.
*McCorkle, R. G., San Antonio.
McCorkle, Robt. G., Jr. (In.), San Antonio.
McCurdy, M. W. (Mil.), San Antonio.
McGehee, Charles L., San Antonio.
McIntosh, John A., San Antonio.
McKee, Robt. D., San Antonio.
McMahan, John W., San Antonio.
McPeak, Edgar M., Boston, Mass.
Mena, A. I., San Antonio.
Merrick, Edward H., San Antonio.
*Milburn, Conn L., San Antonio.
Milburn, Kennedy A., San Antonio.
Mileau, Alexander, Jr., San Antonio.
Miller, J. B., Sr., San Antonio.
Miller, J. B., Jr., San Antonio.
*Miller, Robt. A., San Antonio.
*Minter, Merton M., San Antonio.
Monsalvo, Rudolph O., San Antonio.
Montgomery, Wm. D., San Antonio.
Moore, Geo. B., San Antonio.
Moore, John M., San Antonio.
Moore, O. S., San Antonio.
Moore, S. Foster, Jr., San Antonio.
Morgan, John B., San Antonio.
Mueller, Edwin L., San Antonio.
Mozersky, Victor (Mil.), San Antonio.
Muldoon, Wilfrid E., San Antonio.
Munslow, Ralph A., San Antonio.
Nicholson, J. R., San Antonio.
Nisbet, Alfred A., San Antonio.
Nitschke, Richard E., San Antonio.
Nixon, P. I., San Antonio.
Nixon, Pat I., San Antonio.
Nixon, James W., San Antonio.
Novak, J. J. (Mil.), San Antonio.
Novak, Lumir F., San Antonio.
Novoa, Enrique, San Antonio.
*Nunn, J. A., San Antonio.
O'Brien, Minnie C., San Antonio.
O'Neill, Francis E., San Antonio.
Orlando, A. M., San Antonio.
Owens, Ross, San Antonio.
Oxford, Marvin B. (Mil.), Floresville.
Pagenstecher, Gustav A., San Antonio.
Palmer, Jos. W., San Antonio.
Parker, T. T., San Antonio.
*Parrish, Robert E., San Antonio.
Parsons, John Charles, San Antonio.
Partain, Jack M., San Antonio.
Paschal, Frank L., San Antonio.
Paschal, George H., San Antonio.
*Passmore, B. H., San Antonio.
Passmore, Glenn G. (Mil.), San Antonio.
Pawelek, Vincent S. (Mil.), San Antonio.
Phelps, Gardner D., Ypsilanti, Mich.
Phillips, Claude M., San Antonio.
Pinson, C. C., San Antonio.
*Pipkin, J. Lewis, San Antonio.
Pomerantz, Robt. B., San Antonio.
Ponder, Stewart M., San Antonio.
Post, S. Perry, San Antonio.
*Poth, Duncan O., San Antonio.
*Potthast, Otto J., San Antonio.
*Pressly, Thos. A., San Antonio.
Pridgen, John L., San Antonio.
Pritchett, A. Belvin, San Antonio.
Pyterek, Arthur B. (Mil.), San Antonio.
Rabel, John E., San Antonio.
*Ramsdell, M. A., San Antonio.
Reily, William A., San Antonio.
Reuter, Ernest G., San Antonio.
Reveley, Hugh P., San Antonio.
Reveley, James E. L., San Antonio.
Rhea, Robt. L., San Antonio.
Rice, Lee (Mil.), San Antonio.
Ritch, Allen, San Antonio.
*Roan, Omer, San Antonio.
Robbins, Lewis C., San Antonio.
Roberts, R. A., San Antonio.
*Robertson, Wilbur F., San Antonio.
Rogers, Albert M., San Antonio.
Rosenzweig, Milton M., San Antonio.
Ross, Lloyd I., San Antonio.
Ross, Rex R., San Antonio.
Rothe, Courand N., San Antonio.
Rouse, J. W. H., San Antonio.
*Russ, W. B., San Antonio.
*Russell, Dan A., San Antonio.
Rutherford, Lafe, San Antonio.
Sacks, David R. (Mil.), San Antonio.
Saegert, August H., San Antonio.
Saenz, Daniel, San Antonio.
Salter, John J., San Antonio.
Sample, Roy O., San Antonio.
Schattenberg, H. J., San Antonio.
Schlecte, Marvin C., Houston.
*Schorr, Arthur M., San Antonio.
Scott, Robt. E. (Mil.), San Antonio.
Schuleman, Israel H., San Antonio.
Schwartzberg, Sam, San Antonio.
*Scull, C. E., San Antonio.
Scull, Thos. J. (Mil.), San Antonio.
*Severance, Alvin O., San Antonio.
*Sharp, Thomas H., San Antonio.
Shaw, Thad, San Antonio.
Shefts, Lawrence M., San Antonio.
Shelby, David M. (Mil.), San Antonio.
Shepherd, W. F., San Antonio.
Shipman, E. D., San Antonio.
Shotts, Chester C., San Antonio.
Siever, James M., San Antonio.
*Skinner, Ira Clifton, San Antonio.
Skripa, Chas. F. (Mil.), San Antonio.
Slayter, James E., San Antonio.
Smith, Bernard F., San Antonio.
Smith, John M., Jr. (Mil.), San Antonio.
Soma, Yone, San Antonio.
Sparks, Jno. E., San Antonio.
Stansell, Paul Q., San Antonio.
Stanton, Wm. P. (Mil.), San Antonio.

Steed, P. Frank, San Antonio.
Steele, Virgil S., San Antonio.
Stevenson, Roger S. (Mil.), San Antonio.
Stieler, Albert, San Antonio.
Steinberg, F. W. (Mil.), San Antonio.
*Stout, B. F., San Antonio.
Stovall, Virginia S., San Antonio.
*Stuck, Walter G., San Antonio.
Sutton, Robt. S., Jr., San Antonio.
Sweet, Horace C., San Antonio.
*Swinny, Boen, San Antonio.
*Sykes, E. Meredith, San Antonio.
Taylor, C. W., San Antonio.
Templeton, R. D., San Antonio.
Tennison, Chas. W. (Mil.), San Antonio.
Thomas, Robt. P., Jr., San Antonio.
Thorne, Frederic H., San Antonio.
Thorner, Melvin W., San Antonio.
Thorner, Rosalind S., San Antonio.
Timmins, O. H., San Antonio.
Timmins, Oliver H., Jr., San Antonio.
*Todd, David A., San Antonio.
Tritt, Earl F., San Antonio.
Trivino, Saul S., San Antonio.
*Tucker, Victor C. (Pres.), San Antonio.
Tullos, Hugh S., San Antonio.
Urrutia, Aureliano, Sr., San Antonio.
Urrutia, Carlos, San Antonio.
Venable, Charles S., San Antonio.
Venable, J. Manning, San Antonio.
Walker, Carl J., San Antonio.
Walker, Herman V., San Antonio.
Walthall, Walter, San Antonio.
Ward, Mildred E., San Antonio.
Watts, J. A., San Antonio.
Weatherford, E. W., San Antonio.
Weatherford, Jack M., San Antonio.
Weiss, Victor J., San Antonio.
Wessels, Andrew, San Antonio.
Whitacre, F. Stanley, San Antonio.
Willerson, J. E., San Antonio.
Willerson, William D., San Antonio.
Willerson, Eleanor T., San Antonio.
Williams, Victor H., San Antonio.
*Winter, John W., San Antonio.
Wolf, William M., San Antonio.
Worsham, John W., San Antonio.
Wyatt, Byron W., San Antonio.
Ximenes, Eduardo T., San Antonio.
Zink, Pearl Louise, San Antonio.
Zuschlag, Ella, San Antonio.

COMAL COUNTY MEDICAL SOCIETY

Alverson, Donald R. (Mil.), Ft. Sam Houston.
*Bergfeld, Arthur W. C., New Braunfels.
Frueholz, Bertha (Sec'y), New Braunfels.
Frueholz, Frederick, New Braunfels.
Hagler, Menan C., New Braunfels.
Hinman, Alexander J., New Braunfels.
Karbach, Hylman E., New Braunfels.
Schaefer, John K., New Braunfels.
Wright, Rennie (Pres.), New Braunfels.

GONZALES COUNTY MEDICAL SOCIETY

Cogburn, C. C. (Sec'y), Nixon.
Elder, N. A., Nixon.
Holmes, Geo., Gonzales.
Sievers, Walter A. (Pres.), Gonzales.
Stahl, Lewis J., Gonzales.
Wilhite, Geo. W., Gonzales.

GUADALUPE COUNTY MEDICAL SOCIETY

Davis, Hugh L., Seguin.
Douthitt, Jas. C. B., Seguin.
Heinen, Allen I. (Pres.), Seguin.
Knolle, R. L., Sr., Seguin.
Knolle, R. L., Jr. (Mil.), Seguin.
Mannheimer, Ilse H. (Sec'y), Seguin.
Mannheimer, W. H. (Mil.), Seguin.
Poth, Norman A., Seguin.
Randolph, Vivien P., Schertz.
Williams, Jesse B. (Mil.), Seguin.

KARNES-WILSON COUNTIES MEDICAL SOCIETY

Archer, Cullen W., Floresville.
Blake, John V., Jr. (Sec'y), Floresville.
Bonstetter, Harold J., Kenedy.
Kent, Chas. M., Kenedy.
King, Stephen A., Karnes City.
Martin, Robt. G., LaVernia.
Oxford, Jerry W., Floresville.
Shannon, S. E. (Pres.), Karnes City.
Ware, Ella, Stockdale.
*Jones, Ernest, Kenedy.
Quillian, Causey C., Kenedy.

KERR-KENDALL-GILLESPIE-BANDERA COUNTIES MEDICAL SOCIETY

Birt, John B., Harper.
Black, Axel J., Kerrville.
Bruce, Paul C., Legion.
Dyer, Edward L., Kerrville.
Feller, Lorence W., Fredericksburg.
Fickessen, Wm. R., Kerrville.
Fowler, Jas. L., Ingram.
Gregg, Wm. Earl (Pres.), Kerrville.
Harze, Otto F., Comfort.
Jones, Chas. C., Comfort.
Jones, Chas. C., Jr., Kerrville.
Keidel, Victor, Fredericksburg.
Keyser, Lester L., Fredericksburg.
*Knapp, Dwight R., Kerrville.
Matthews, Choice B., Kerrville.
*McClellan, Clarence L., Kerrville.
*McCollough, David, Kerrville.
Moore, Carol L., Legion.
Packard, D. E. (Sec'y), Kerrville.
Perry, Jas. H., Fredericksburg.
*Simpson, Robt. K., Kerrville.
*Thompson, Samuel E., Kerrville.
Tubbs, Harry A., Fredericksburg.
Wiedeman, Jno. E., Junction.

LaSALLE-FRIO-DIMMITT COUNTIES MEDICAL SOCIETY

*Bannister, Mortimer H. (Sec'y), Pearsall.
Barnard, W. L., Carrizo Springs.
Beall, Judson E., Pearsall.
Beall, Wendell E. (Pres.), Pearsall.
Cook, Jno. A., Cotulla.
Crawford, John M., Carrizo Springs.
Fay, Harold W., Dilley.
Goodnight, Jas. E., Pearsall.
Howard, Elmer M., Pearsall.
Howard, Glenn T., Pearsall.
Lightsey, John N., Cotulla.
Lindley, Calvin D., Carrizo Springs.
*Payne, Peel M., Asherton.
*Pickett, Britton E., Sr., Carrizo Springs.
Woods, Geo. S., Devine.

MEDINA-UVALDE-MAVERICK-VAL VERDE-TERRELL-EDWARDS-REAL-McKINNEY-ZAVALA COUNTIES MEDICAL SOCIETY

Burditt, Bucky Lee, Del Rio.
*Cox, Geo. W., Austin.
Crossley, S. W., Del Rio.
Cunningham, Geo. B., Uvalde.
*Dimmitt, Dean P., Uvalde.
Donaldson, Elizabeth, Del Rio.
Gates, Ellis F., Eagle Pass.
Graham, R. Norvill, Del Rio.
Horton, J. J., Eagle Pass.
LaForge, Hershall (Pres.), Uvalde.
McMillan, Orin P. (Sec'y), Eagle Pass.
*McWilliams, W. R., Del Rio.
Meredith, W. P., Del Rio.
Merritt, Geo. H., Uvalde.
Montemayor, Raul M., Eagle Pass.
*Poindexter, Cary A., Crystal City.
Sanders, Joe I., Del Rio.
Schulze, E. C., Del Rio.
*Turner, John R., Uvalde.
*Utterback, Alvin P., Brackettville.
Williamson, Jas. D., Castroville.

SIXTH OR CORPUS CHRISTI DISTRICT

Dr. W. E. Whigham, McAllen, Councilor.

BEE-LIVE OAK-McMULLEN COUNTIES MEDICAL SOCIETY

Barnhart, Joe M., III (Mil.), Beeville.
*Davis, David Wm., Three Rivers.
Edmondson, John W., Beeville.
Gipson, Carie D., Three Rivers.
*Kirkland, Luman W., Beeville.
Lancaster, Howard E., Beeville.
McNeill, Scott E., Beeville.
Miller, Ernest E. (Sec'y), Beeville.
Poff, Claud M., Tuleta.
Reagan, Tom B., (Pres.), Beeville.
Sansom, Geo. W., George West.
Williamson, Chas. D., Three Rivers.

BROOKS-DUVAL-JIM WELLS COUNTIES MEDICAL SOCIETY

Atkinson, Newell W., Alice.
Behrns, Chas. L., Alice.
Dozier, Jos. V., Premont.
Duran, C. Armando, Victoria.
Gaston, Earl, Falfurrias.
Gonzalez, Juan C., Benavides.
Joseph, Phillips S. (Sec'y), Alice.
Moet, Jno. A. (Pres.), Orange Grove.
*Otkin, Chas. H., Falfurrias.
Sory, Crysup, Freer.
*Strickland, Jno. H., Alice.
Thomas, Jas. H., Freer.
Veit, Jno. P., Falfurrias.
Winfield, C. F., Alice.
Wyche, Geo. G., Alice.

CAMERON-WILLACY COUNTIES MEDICAL SOCIETY

Allen, Geo. Earl, Harlingen.
Amidon, Chas. S., Harlingen.
Amidon, Vivian M., Harlingen.
Andrews, Thos. P., Brownsville.
Ashcraft, E. Jeff, Harlingen.
Baden, Erwin E., Raymondville.
Bartlett, Merrill S., Brownsville.
Bennack, Geo. E., Raymondville.
Bleakney, Phil A. (Mil.), Harlingen.
Breeden, Roy F., Brownsville.
Caldeira, Frederick D., Harlingen.
Calderoni, Francisco F., Brownsville.
Carranza, Enrique, M., Brownsville.
Casey, Jas. D., San Benito.
Cash, Clarence M., San Benito.
Cole, Benj. L. (Hon.), Brownsville.
Conley, Chas. C., Raymondville.
Dashiell, Geo. R., Jr., Brownsville.
Davidson, Noah A., Harlingen.
Davis, Lum M., Harlingen.
Dawson, Calvin DeWitt, San Benito.
*Deaton, David Grady, Galena Park.
Eisaman, Ralph H., Brownsville.
Englerth, Fred L., Harlingen.
Gallaher, Geo. L., Harlingen.
Haas, Nelson W., San Benito.
Harris, Wylie H. (dead), Raymondville.
Harrop, Leon Louis, Harlingen.
Hawkins, Beatrice W., Brownsville.
Heins, Otto Henry W., Lyford.
Kinder, Thurman A., Jr. (Mil.), Brownsville.
*Kitchens, Walter L., San Benito.
Lamm, Annie Thea, LaFeria.
Lamm, Heinrich, LaFeria.
LaMotte, Thos. J. (Pres.), Harlingen.
Lawrence, Oscar V., Brownsville.
Letzerich, Alfred M., Harlingen.
Longoria, Vidal, Brownsville.
Lyle, Chas. F., San Benito.
Merrill, Samuel J., Brownsville.
Moet, Joe Louis, LaFeria.
Olcott, Cornelius, Jr., Harlingen.
Para, Wandre W. (Mil.), Brownsville.
Peek, John S. (Mil.), Brownsville.
Pilmer, Gordon A. (Sec'y), Harlingen.
*Pollard, Albert J., Harlingen.
Pope, Andrew J., LaFeria.
Rodriguez, Hesequio, Rio Hondo.
Scales, Hunter L., San Benito.
Scanlan, Nestor (Mil.), Brownsville.
*Shafer, Troy A., Harlingen.
Sherman, K. C., Harlingen.
Smith, French Nestor, Harlingen.
Sprinkle, Davis L., Harlingen.
Trible, John J., Brownsville.
Turner, Wm. Robert, Harlingen.
*Utley, Ralph E., Harlingen.
Vinsant, Wm. J., San Benito.
Walsworth, Frank D., Harlingen.
*Watkins, Jno. C., Harlingen.
*Works, Bynum M., Brownsville.

HIDALGO-STARR COUNTIES MEDICAL SOCIETY

Bowman, Newton H. (Hon.), Mercedes.
Buck, Chas. B., Mercedes.
Calderira, Anton D., Mercedes.
Casey, Jno. B., McAllen.
Caton, McKee, McAllen.
DeWitt, J. L., Elsa.
Edgerton, Mary H., Rio Grande.
Frenzel, Paul H., Donna.
Glass, T. W., Weslaco.
Guerra, Gilbert A., Edinburg.
Hamme, Curtis J., Edinburg.
Hamme, Ralph E. (Pres.), Edinburg.
Hatfield, Walter H., McAllen.
Helm, Karl G., Alamo.
Ice, Noel C., McAllen.
Ivy, J. Bryan, Weslaco.
Johnston, Robt. H., Mercedes.
Lancaster, Geo. M., Weslaco.
Lawler, Marion R., Mercedes.
Lockhart, Jesse P., Brady.
Long, Wm. Harvey, Pharr.
*Lubben, J. F., Jr., McAllen.
Mann, Harold W., McAllen.
Mannering, Melvin D., Alamo.
Martin, Chas. J., Huntsville, Ark.
May, Joe W., Edinburg.

McCalip, Edwin L., Weslaco.
McKinsey, S. Joe, McAllen.
Mock, Duane V., San Juan.
Moore, L. H., McAllen.
*Osborn, Alfred S., McAllen.
Osborn, Frank E., McAllen.
Palisano, Phillip A., McAllen.
Parker, H. E., Donna.
Pence, Roy W., San Juan.
Reed, Walter E., San Juan.
Rodriguez, M. J., Rio Grande.
Schalenben, Henry O., Edinburg.
Scott, Kincy J., Pharr.
Smith, Edward G., Mercedes.
Smith, Mouldon, Mission.
Southwick, Lloyd M. (Sec'y), Edinburg.
*Sybilrud, H. W., McAllen.
Walker, Ottis, Mission.
Webb, J. G. (dead), Mercedes.
Wells, Edmond D., Mercedes.
Westphal, Herbert M., Weslaco.
Wharton, J. O., McAllen.
*Whigham, H. E., McAllen.
*Whigham, W. E., McAllen.

KLEBERG-KENNEDY COUNTIES MEDICAL SOCIETY

Barnett, Lawrence M., Bishop.
*Brindley, Claunch G., Kingsville.
Ewert, Wm. A. (Sec'y), Kingsville.
Jones, Augustus C., Kingsville.
Mitchell, Robt. H., Kingsville.
Noel, Livingston P., Jr., Kingsville.
Peace, Dewey W. (Pres.), Bishop.
Reed, Theodore D., Kingsville.
Shelton, Jos. H., Jr., Kingsville.
Sublett, Collier M., Kingsville.

NUECES COUNTY MEDICAL SOCIETY

Appel, Myron H. (Mil.), Corpus Christi.
Arnim, Landon C. (Mil.), Corpus Christi.
Ashmore, Alvin J. (Mil.), Corpus Christi.
Averhack, Bert F., Corpus Christi.
Baldwin, Harvey C. (Mil.), Corpus Christi.
Barker, Wm. E. (Mil.), Corpus Christi.
Barnard, Wm. C., Corpus Christi.
Brown, Walter C., Corpus Christi.
Carter, N. Dilford, Corpus Christi.
Clark, Dan H., Corpus Christi.
*Cline, W. B., Jr. (Mil.), Corpus Christi.
Collins, Clarence B., Corpus Christi.
Colyer, Geo. E. (Mil.), Corpus Christi.
Concklin, C. Lewis, Corpus Christi.
Crain, Carroll F., Corpus Christi.
Danford, Edwin A., Corpus Christi.
Davis, Walter T., Corpus Christi.
Eckhardt, Kleberg (Mil.), Corpus Christi.
Edgerton, Geo. W., Corpus Christi.
Edwards, Thomas W. (Pres.), Corpus Christi.
Ellis, Frank A. (Mil.), Corpus Christi.
*Frank, Thelma E., Corpus Christi
Frasheur, Wm. E., Robstown.
*Friedman, Bernard B., Corpus Christi.
Gaddis, H. W. (Mil.), Corpus Christi.
Garcia, Hector, Corpus Christi.
Garcia, Jose A., Corpus Christi.
*Garrett, Leslie M. (Mil.), Corpus Christi.
Gentry, Wm. H., Corpus Christi.
Ghormley, Mary O., Corpus Christi.
*Ghormley, Wm. C. (Mil.), Corpus Christi.
*Gibson, Norman T., Robstown.
Giles, E. Jack, Corpus Christi.
Giles, Henry R., Corpus Christi.
Gill, E. King (Mil.), Corpus Christi.
Graham, Alice E., Corpus Christi.
Gray, Paul M. (Mil.), Corpus Christi.
Grossman, Bernard B. (Mil.), Corpus Christi.
Grossman, Dave N. (Mil.), Corpus Christi.
Grossman, Saul, Corpus Christi.
*Guttman, L. P., Corpus Christi.
Heaney, Harry G., Corpus Christi.
Heaney, H. Gordon, Corpus Christi.
Hollister, Wm. L., Corpus Christi.
Horbaly, William, Corpus Christi.
*Janssen, L. W. O., Corpus Christi.
Jasperson, Clarence P., Corpus Christi.
Kelly, Francis B., Corpus Christi.
Kemp, Kenneth J., Corpus Christi.
Kennedy, Hugh A. (Mil.), Corpus Christi.
*Landesman, Jos. D., Corpus Christi.
*Marler, O. E., Corpus Christi.
Mathis, Edgar G., Corpus Christi.
McBride, Wm. L., Corpus Christi.
*McLaughlin, R. L., Corpus Christi.
Meador, C. N., Corpus Christi.
*Moller, G. Turner, Corpus Christi.
Moody, Foy H. (Sec'y), Corpus Christi.
Morgan, Chas. G., Corpus Christi.
Nast, Jerome, Corpus Christi.
Oliphant, T. Hillman, Corpus Christi.
Perkins, Maury J., Corpus Christi.
*Pilcher, John F., Corpus Christi.
Portela, Adolfe P., Corpus Christi.
*Prothro, Ernest W., Legion.
Rhodes, William L., Corpus Christi.
Rosenheim, Phillip, Corpus Christi.
Roundtree, James T., Corpus Christi.
Sharp, James C. (Mil.), Corpus Christi.
Shinn, A. Lewis (Mil.), Corpus Christi.
Sigler, Robt. J. (Mil.), Corpus Christi.
Sloan, Joe M. (Mil.), Corpus Christi.
*Smith, Youel C., Corpus Christi.
*Stewart, Chas. D., Corpus Christi.
*St. John, R. V., Corpus Christi.
Stroud, S. K. (Mil.), Corpus Christi.
Swearingen, Robt. G. (Mil.), Corpus Christi.
Talley, O. H., Corpus Christi.
Thomas, Jorn R., Corpus Christi.
Triplett, Wm. C. (Mil.), Corpus Christi.
Watson, Clyde O., Corpus Christi.
White, H. A., Corpus Christi.
Williamson, C. M., Corpus Christi.
Wright, Virginia L. (Mil.), Portola, Cal.
Yates, June, Corpus Christi.
*Yeager, Chas. P., Corpus Christi.
Yeager, Franklin W. (Mil.), Corpus Christi.

SAN PATRICIO-ARANSAS-REFUGIO COUNTIES MEDICAL SOCIETY

Bull, John B., Aransas Pass.
Cockerham, Louis H., Sinton.
*Cron, Chas. F., Rockport.
Curlee, Curtis Leo, Sinton.
Ewing, F. Stanley (Mil.), Sinton.
*Finn, John H., Refugio.
Flynn, Eugene (Mil.), Refugio.
Glover, Geo. E., Austwell.
Guynes, Wm. A., Mathis.
*Jenkins, Young S. (Sec'y), Taft.
Kendrick, M. C., Ingleside.
Koontz, A. C., Woodsboro.
Meitzen, Travis C., Refugio.
Shelton, Josephine A., Refugio.
Shipp, H. H., Woodsboro.
Tasch, A. F., Taft.
Tompkins, Donald R. (Pres.), Refugio.
Tunnell, Jno. W. (Mil.), Gregory.
Voss, Alpheus H., Odem.
Woods, Haddon B. (Mil.), Refugio.
Zarsky, Emil P. (Mil.), Refugio.

WEBB-ZAPATA-JIM HOGG COUNTIES MEDICAL SOCIETY

Candlin, Geo. H., Laredo.
Canseco, Francisco M., Laredo.
*Carrithers, Clem M., Hebbronville.
Chapa-Badillo, Jesus, Laredo.
Cigarroa, Joaquin G., Laredo.
Cook, Albert T., Laredo.
Crawford, Jas. L. (Pres.), Laredo.
de la, Garza, Raul, Laredo.
Graham, Steven H., Laredo.
Longoria, Enrique M., Laredo.
Lowry, Jno. T. (Sec'y), Laredo.
Lowry, Ruby S., Laredo.
Malakoff, Morris E., Laredo.
Montalvo, Lauro, Zapata.
*Musacchio, F. A., Laredo.
Penny, George E., Laredo.
*Powell, Wm. R., Laredo.
Puig, Valentine L., Jr., Laredo.
Roach, Thos. S., Laredo.
Rottenstein, Max, Laredo.
Wright, Ray B., Laredo.

SEVENTH OR AUSTIN DISTRICT

Dr. R. T. Wilson, Austin, Councilor.

BASTROP COUNTY MEDICAL SOCIETY

Bryson, J. Gordon, Bastrop.
Fleming, Joe V. (Sec'y), Elgin.
Heatley, M. L., Bastrop.
Hoch, Chas. M. Sr. (Dead), Smithville.
Hoch, Chas. M., Jr., Smithville.
Kroulik, F. J., Smithville.
Stephens, J. D., Smithville.
Wood, W. E. (Pres.), Elgin.

CALDWELL COUNTY MEDICAL SOCIETY

DuBoise, Otho K. (Pres.), Lockhart.
Luckett, Francis C., Fentress.
Nickols, H. Clay, Sr., Luling.
Nickols, H. Clay, Jr., Luling.
O'Banion, Jno. T., Luling.
Pitts, Minor W., Luling.
*Ross, Alonzo A., Sr., Lockhart.
*Ross, Abner A., Jr. (Mil.), Lockhart.
*Ross, Raleigh (Mil.), Lockhart.
Smith, Edgar, Lockhart.
*Watkins, Walter P. (Sec'y), Luling.
Wilson, Francis W., Luling.

HAYS-BLANCO COUNTIES MEDICAL SOCIETY

*de Steiguer, John R. (Sec'y), San Marcos.
Edwards, Louis L. (Dead), San Marcos.
Flannery, John J., Blanco.
Kealey, Edward T., Johnson City.
Lancaster, York, San Marcos.
Lauderdale, Clay, Buda.
Sowell, Rugel F., San Marcos.
*Van Ness, Julius M., San Marcos.
White, David L., San Marcos.
Williams, Milton C. (Pres.), San Marcos.

LAMPASAS-BURNET-LLANO COUNTIES MEDICAL SOCIETY

Allen, Geo. S., Burnet.
Black, D. W., Lampasas.
Brooks, W. M., Lampasas.
Fowler, Wert D., Eden.
Gaddy, H. R., Lampasas.
Gray, Geo. L. (Pres.), Llano.
*Hoerster, H. J., Llano.
Hoerster, Sam A. (Mil.), Llano.
Landrum, Marvin M., Lampasas.
Rollins, H. B., Lampasas.
*Shepperd, Joe A. (Sec'y), Burnet.
Shepperd, Ray L., Llano.
*Shepperd, Roy R., Burnet.
Vaughn, Thos. D., Bertram.

LEE COUNTY MEDICAL SOCIETY

Mantzel, Sherwood W. (Pres.), Giddings.
York, Wm. E. (Hon.), (Sec'y), Giddings.

TRAVIS COUNTY MEDICAL SOCIETY

Allison, Bruce, Abilene.
Auler, Hugo A., Austin.
Baggett, Seldon O., Austin.
Bailey, Chas. W., Austin.
Bain, Ruth M., Austin.
Barker, Paul W., Austin.
*Bintleff, Chas. V., Austin.
Black, W. B., Austin.
Blaustone, Henry H., Austin.
*Bohls, S. W., Austin.
Brady, J. J., Austin.
Bratton, Robt., Austin.
Brown, M. I., Austin.
Brownlee, C. H., Austin.
Carter, C. E., Austin.
Carter, Rexford G., Austin.
Castner, Chas. W., Austin.
Chauvin, Eustace V., Jr., Austin.
Chrisman, Wm. P., Austin.
Clark, Simon J., Austin.
*Cleveland, G. W., Austin.
*Cloud, Ralph E., Austin.
Coleman, Jas. M., Austin.
Conn, Leslie D., Crystal City.
Cooper, R. A., Austin.
Cooper, S. S. (Mil.), Austin.
Creel, Wylie F., Austin.
Crockett, Jno. A., Austin.
Crowell, Caroline, Austin.
Darnall, Chas M. (Mil.), Austin.
Davidson, Harry T., Austin.
Davis, Nathan (Mil.), Austin.
Dildy, Chas. B., Austin.
Dinwiddie, Robt. A., Austin.
Dryden, S. H., Austin.
Dyson, Thos. N. San Antonio.
Eckhardt, Jas. W., Austin.
Eckhardt, Joe C. A., Austin.
*Edens, Lee E., Austin.
Eppright, Ben R., Austin.
Esquivel, Sandi, Austin.
*Gambrell, Wm. M., Austin.
Garcia, Alberta G., Austin.
Gibson, J. W., Austin.
Gilbert, Joe, Austin
Gilbert, Joe T., Austin.
Goddard, Walter C., Austin.
Gondolf, Harold J., Austin.
Gore, Wm. A., Austin.
Granberry, Howard, Jr., Austin.
*Gregg, F. Banner, Austin.
Hahn, Wm. B., Austin.
Hanna, Ralph, Austin.
*Hardwicke, Chas. P. (Pres.), Austin.
*Harris, Woodson Weldon, Austin.
Hay, Bruce H. (Mil.), Austin.
Heitzman, Celine I., Austin.
Henry, H. B., Austin.
Herrod, Jas. H., Austin.
*Hilgartner, H. L., Jr. (Sec'y), Austin.
Holland, Lang F., Austin.

Holtz, Harvey E., Austin.
Houston, Wm. R., Austin.
*Jackson, J. Warren, Austin.
Jaehne, Robt. J., Austin.
Johnson, J. Edward, Austin.
Jordan, R. C. (Mil.), Austin.
Kelton, W. W., Jr., Austin.
Key, Sam N., Austin.
Klint, Hugo A., Austin.
Klotz, H. L., Austin.
Kreisle, M. F., Austin.
Lippman, Otto (Mil.), Austin.
Loving, Jas. M., Austin.
Loving, Maribel, Austin.
Martin, Claud A. (Mil.), Austin.
McCauley, Morris D., Austin.
McCormick, Katharine, Austin.
*McCrummen, Thos. D., Austin.
*McElhenney, Thos. J., Austin.
Merrick, Benjamin A., Austin.
Middlebrook, F. M., Austin.
Miears, Claud H., Austin.
Milligan, Barth, Austin.
Morgan, W. P., Austin.
Morris, Truman N., Austin.
*Morrison, Robt. B., Austin.
Murray, R. V., Austin.
Nanney, Audie L., Austin.
Neighbors, A. H., Austin.
Newman, H. W., Austin.
Nichols, Jas. R., Austin.
Paggi, Leonard C., Austin.
Paine, Henry C., Austin.
Paris, P. J., Austin.
*Paterson, Elizabeth, Austin.
Peavy, Chas. D., Austin.
Price, Enoch C. (Mil.), Austin.
*Primer, B. M., Austin.
Rabb, Virgil S., Jr., Austin.
Rice, Albert J., Austin.
*Richardson, Dalton, Austin.
Robinson, Harold L., Austin.
*Robinson, Wm. Lee, Austin.
*Robison, Jas. T., Austin.
Rothen, Robt. M., Austin.
Saldivar, Julian T. (Mil.), Austin.
Schiller, Nelson L., Austin.
*Scott, H. A., Austin.
Scott, Z. T., Austin.
Shane, Hugh (Mil.), Austin.
*Simpson, J. D., Austin.
*Smith, Howard E., Austin.
Smith, Lawrence T., Austin.
*Standifer, C. H., Terrell.
*Suehs, Oliver W., Austin.
Suehs, P. E., Austin.
Swift, Edward V. (Mil.), Austin.
Terry, A. A., Austin.
Thomas, Harold R. (Mil.), Austin.
Thomas, J. C., Austin.
Thompson, Burch, Austin.
*Thornhill, G. F., Austin.
*Tisdale, Albert A., Austin.
Tisdale, Marie Correll, Austin.
Vieth, Richard P. (Mil.), Austin.
Wade, David, Austin.
*Walter, Luthur P., Austin.
Watt, Terrence N., Austin.
Watt, Will E., Austin.
*Weaver, John D., Austin.
White, B. O., Austin.
*White, Forest A., Austin.
*White, Paul L. (Mil.), Austin.
Willess, Hershel F., Austin.
Williams, Harold L., Austin.
Williams, Harriss, Austin.
Williams, Wm. E. (Mil.), Austin.
Wilson, Jas. D., Austin.
*Wilson, R. T., Austin.
Woodson, Burbank Palmer, Austin.
Woolsey, S. A., Austin.
Wooten, Joe S., Austin.
Zedler, Garland G., St. Louis, Mo.

WILLIAMSON COUNTY MEDICAL SOCIETY

Alexander, Margaret H., Taylor.
Atkinson, Ozias B., Florence.
Clark, J. Frank, Georgetown.
Cooper, Dewey H., Georgetown.
Crawford, Clyde H., Bartlett.
Doak, Edmond, Taylor.
Feaster, Hessie, Taylor.
Gregg, D. B., Round Rock.
*Johns, Jay J. (Sec'y), Taylor.
*Kirkpatrick, B. A., Taylor.
Kirkpatrick, Roy H. (Mil.), Taylor.
Martin, Jno. R., Georgetown.
Ross, Geo. D., Liberty Hill.
*Sharp, Milton R., Granger.
Stromberg, Eric W., Taylor.
Swanson, Wayland R., Taylor.
Wedemeyer, Wm. C. (Pres.), Walburg.
Wheeler, H. P., Georgetown.

EIGHTH OR DeWITT DISTRICT

Dr. F. J. L. Blasingame, Wharton, Councilor.

COLORADO-FAYETTE COUNTIES MEDICAL SOCIETY

Beckman, Paul, LaGrange.
Boelsche, Leslie D., LaGrange.
Cook, Chas. G. (Hon.), Weimar.
Guenther, Frank J., LaGrange.
Guenther, Jno. C., LaGrange.
Kieke, August W., Round Top.
Kirkham, S. H., Columbus.
Laughlin, Jones C., Eagle Lake.
*Laughlin, John R., Eagle Lake.
Leudemann, W. O., Schulenburg.
Miller, Arthur C., Carmine.
Peters, Leo J. (Pres.), Schulenburg.
*Potthast, Adolph H., Weimar.
*Rockett, Fred W. B., Flatonia.
Shult, C. I. (Sec'y), Columbus.
Svrcek, Edwin R., LaGrange.
*Wooten, James H., Jr., Columbus.
*Youens, Thomas, Weimar.

DeWITT COUNTY MEDICAL SOCIETY

Arnecke, C. A. H., Arneckeville.
*Bohman, Alfred J. Cuero.
Brown, Harry H., Jr., Yoakum.
*Burns, John G., Cuero.
Cross, Geo. W. (Pres.), Yorktown.
Dobbs, Jas. C., Cuero.
Douthit, Walton E., Cuero.
Duckworth, Guliford M., Cuero.
*Eckhardt, Herman C., Yorktown.
Milner, Robt. M., Yoakum.
Nau, Carl A., Galveston.
Norwierski, Leon W., Yorktown.
O'Quinn, C. Lafayette, Weesatche.
Prather, Frank A., Cuero.
*Richter, Louis B. S. (Sec'y), Yoakum.
*Westphal, Corinne, Yorktown.
Westphal, Robt. D. (Mil.), Yorktown.

LAVACA COUNTY MEDICAL SOCIETY

Boyle, Jas. W., Jr., Shiner.
Clayton, Stanley L. Hallettsville.
Dufner, C. T., Hallettsville.
Jaeggli, Sam, Moulton.
Kopechy, Chas. L., Shiner.
*Marek, E. H., Yoakum.
*Renger, Harvey, Hallettsville.
Strieder, Hugo J. (Sec'y), Moulton.
Wagner, Frank M., Shiner.
Williams, Robt. W. (Pres.), Shiner.

VICTORIA-CALHOUN-GOLIAD COUNTIES MEDICAL SOCIETY

DeTar, Webb T., Victoria.
Ehlert, Edward A., Jr., Victoria.
Fry, Francis Polk, Jr., Victoria.
Gunter, Jos. T., Goliad.
Hopkins, Jos. V. (Pres.), Victoria.
Lander, Roy S. (Sec'y), Victoria.
Lester, Stanley W., Port Lavaca.
Mosley, Robt. A., Victoria.
Roemer, Fred J., Port Lavaca.
Sale, Walter W., Victoria.
Shields, Allan C., Victoria.
Shields, Fred B., Victoria.
Smith, David Heaton, Victoria.
Ward, Rawley W., Victoria.

WHARTON-JACKSON-MATAGORDA-FORT BEND COUNTIES MEDICAL SOCIETY

Andrews, Judson M., Wharton.
*Balke, John W., Rosenberg.
Barbour, J. Lane, Bay City.
Bauknight, J. M. (Sec'y), Ganado.
*Black, Vernon A., Wharton.
*Blair, Wm. M., Wharton.
*Blasingame, F. J. L., Wharton.
*Brewer, Paul L., Bay City.
*Byrd, Wallace, Wharton.
Davidson, G. L., Wharton.
Davidson, T. L., Wharton.
Dye, Fulton E., Bay City.
Guffy, Joseph L., Palacios.
Halamicek, J. A., El Campo.
Halamicek, Jno. F., El Campo.
*Johnson, Leonard B., El Campo.
*Johnson, R. G., New Gulf.
Knolle, Ben E., Sugarland.
Loos, Henry H., Bay City.
McGee, Borden M., Rosenberg.
Neal, T. M., Wharton.
Nichols, C. V., Richmond.
Outlar, L. Bolton, Wharton.
Reeves, H. V., El Campo.
Rugeley, Frank R., Wharton.
Schulze, Gustave A., El Campo.
*Schumann, J. Daniel, East Bernard.
*Shoultz, Chas. A., Bay City.
Simons, Bryan E., Bay City.
Simons, J. W., New Gulf.
Slaughter, Carlos A., Sanitorium.
Thiltgen, Winston S. (Pres.), El Campo.
Wagner, J. R., Palacios.
Weeks, Jno. W., Rosenberg.
Weinheimer, E. A., El Campo.
Whitfield, Walter E., Edna.
Williams, Jarrett E., Wharton.
Yates, Chas. W., Rosenberg.
*Yelderman, Robt. L., Rosenberg.
Zipp, Raymond P., Edna.

NINTH OR SOUTHERN DISTRICT

Dr. Ghent Graves, Houston, Councilor.

AUSTIN-WALLER COUNTIES MEDICAL SOCIETY

Gordon, Virgil, Sealy.
*Hackfield, Alfred J., Industry.
Hoover, Frank W., Sealy.
Neely, Jubol A. (Pres.), Bellville.
Neely, Robt. Allen, Bellville.
Roensch, Herbert E. (Sec'y), Bellville.
Steck, Otto E., Bellville.
*Walker, Sidney C., Hempstead.
Witte, B. O., Fayetteville.

BRAZORIA COUNTY MEDICAL SOCIETY

*Cox, Walter E., Angleton.
Galloway, William T., Freeport.
Gray, Ralph E., Lake Jackson.
Greenwood, Wm. M. (Pres.), West Columbia.
Hampil, C. C., Brazoria.
Hayes, G. J., Alvin.
*Holt, William C., Angleton.
McCary, Augustus O. (Sec'y), Freeport.
McCary, Roger M., Freeport.
Merz, Herbert E., Alvin.
Miller, Robert C., Velasco.
Muetz, Walter, Pearland.
Nicholson, William D., Freeport.
*Reeves, George D., Freeport.
*Ryan, William G., Velasco.
Slaughter, S. B., Velasco.

BURLESON COUNTY MEDICAL SOCIETY

Goodnight, Thos. L. (Sec'y), Caldwell.
Kozar, Jos. (Hon.), Somerville.
*Pozdral, Geo. V., Somerville.
*Siptak, Jno. E. (Pres.), Caldwell.

GALVESTON COUNTY MEDICAL SOCIETY

*Anderson, Wm. T., LaMarque.
*Andronis, Nicholas, Galveston.
Aves, Fred W., Galveston.
*Baxter, Virgil C., Galveston.
Beeler, Geo. W., Texas City.
*Blocker, Truman G. (Mil.), Galveston.
*Blocker, Virginia I., Galveston.
*Brindley, Paul, Galveston.
*Caravageli, M. A., Galveston.
*Cone, Robt. E., Galveston.
Cooke, Willard R., Galveston.
*Delaney, John J., Galveston.
Danforth, Duncan R., Texas City.
*Decherd, Geo. M., Galveston.
*Eggers, Geo. W. N., Galveston.
*Ewalt, Jack R., Galveston.
*Fisher, Wm. C., Jr., Galveston.
Fleming, Ben P., Texas City.
*Ford, Hamilton F., Galveston.
*Frank, Theodore Mc., Texas City.
Frazier, Chester N., Galveston.
*Garbade, Francis A. (Pres.), Galveston.
*Gilliam, Cecil Hughes, Galveston.
*Gregory, Raymond L., Galveston.
*Hansen, Arild E., Galveston.
*Harris, Titus H., Galveston.
*Herrington, D. J., Texas City.
*Herrmann, Geo. R., Galveston.
Hoecker, Wade L., Galveston.
Hoeflich, Werner F. (In.), Galveston.
*Hooks, Chas. A., Galveston.
Jarvis, Garth L. (In.), Galveston.
Jarrell, Norman D., Texas City.
Jinkins, A. J., Galveston.
*Jinkins, Julius L., Galveston.

*Jinkins, Wiley J. (Hon.), Galveston.
*Jinkins, Wiley J., Jr., Galveston.
*Johnson, Jesse B., Galveston.
*Kennedy, J. C., Galveston.
Klatt, Emil H., Galveston.
*Kolb, Weldon G., LaMarque.
Lee, Geo. T., Galveston.
*Lefeber, Edw. J., Galveston.
*Levin, Wm. C., Galveston.
*McGivney, Jno. (Sec'y), Galveston.
McKinley, W. Frank, Marlin.
*McLarty, E. S., Galveston.
*McReynolds, Geo. S., Galveston.
*Magliolo, Andrew, Dickinson.
*Magliolo, Jos. C., Dickinson.
Manske, Gerhard R., Texas City.
*Mares, Charles F., Galveston.
*Marr, Wm. L., Galveston.
*Middleton, John W., Galveston.
*Moore, Robert M., Galveston.
*Otto, Jno. L., Galveston.
*Perlman, Bernard, Galveston.
*Poetter, H. W., Galveston.
*Poth, Edgar J., Galveston.
*Potter, Wm. B., Galveston.
*Prujansky, Nathan, Galveston.
*Randall, Edw., Jr., Galveston.
Reading, Wm. Boyd, Galveston.
*Ritchie, Earl B., Galveston.
Roland, Robt. H., Jr., Galveston.
*Robinson, H. Reid, Galveston.
*Ross, Marcus Lamar, Galveston.
Schmidt, Henry A., Texas City.
*Schofield, Norman D., Galveston.
Schwab, Edward H., Galveston.
*Shelton, Fred W., Galveston.
*Spiller, Wm. F., Galveston.
*Sharp, Wm. B., Galveston.
*Singleton, Albert O., Galveston.
*Slocum, Harvey C., Galveston.
*Snodgrass, Samuel R., Galveston.
*Starley, Wm. F., Galveston.
*Stephen, Weldon W., Galveston.
*Stone, Chas. T., Galveston.
*Sweets, Henry H., Galveston.
*Sykes, Clarence S., Galveston.
*Thiel, Jno. M., Galveston.
*Thompson, Edward R., Galveston.
Tomlinson, Lou M., Galveston.
Twidell, Leonard, Texas City.
*Wilkinson, E. E., Galveston.
*Wall, Dick P., Galveston.
Wallace, Wm. S., Galveston.
*Weinert, Herman, Jr., Galveston.
*Weisz, Stephen, Galveston.
White, Weldon C. (Mil.), Galveston.

GRIMES COUNTY MEDICAL SOCIETY

*Coleman, S. D., Navasota.
Hansen, Carl M., Washington.
Harris, G. C., Jr., Navasota.
Ketchum, E. T., Navasota.
Parker, M. E., Anderson.
Sanders, G. C. (Pres.), Richards.
Stewart, H. L. (Sec'y), Navasota.

HARRIS COUNTY MEDICAL SOCIETY

*Adam, Geo. F., Houston.
Adams, Granville Q., Houston.
Agnew, Jas. H., Houston.
*Alexander, Chas. S., Houston.
Alexander, Herbert L. (Sec'y), Houston.
*Alexander, Jewel C., Houston.
Allen, Leonardo, Houston.
Ames, Frederick D., Houston.
Andrews, Tom A., Jr., Houston.
Applebe, Edw. W., Houston.
Archer, Palmer M., Houston.
Armentrout, Coral R., Houston.
*Arnold, E. M., Houston.
*Ashmore, C. M., Houston.
*Aves, Delano R., LaPorte.
Axelrod, A., Houston.
Aydam, Chas. W., Houston.
Baird, J. Byron, Pasadena.
*Baird, Val C., Houston.
Barkley, Howard T., Houston.
Barnebee, Jas. H., Jr. (Mil.), Houston.
*Barnes, J. Peyton, Houston.
Barr, Allen W., Houston.
*Barrett, Jno. H., Houston.
Bartlett, Henry L. (Mil.), Houston.
Bayer, Bernard H., Houston.
Behrens, Chas. A., Houston.
Bell, Justin E., Houston.
Bell, Wm. E. (Mil.), Houston.
Belleggi, Philip A., Houston.
Bennett, Wm. H., Humble.
Berry, Chas. R., Houston.
*Bertner, E. W., Houston.
Best, Paul W., Houston.
*Bickel, Laura C., Houston.
*Billups, J. T., Houston.
*Blair, Lyman C., Houston.
*Blair, Robert K., Houston.
*Blish, M. Eleanor, Houston.
Bloom, Fred A., Houston.
*Bloom, Manuel G., Houston.
*Bloxsom, Allan P., Houston.
*Blundell, Jas. Reese, Houston.
Blue, J. S., Los Angeles.
*Boardman, Harriett L., Houston.
*Bonham, Russell F., Houston.
Bonin, Wilfred P., Houston.
*Bost, Jas. R., Houston.
Bourdon, Lynn L., Houston.
*Bowen, Ralph, Houston.
*Bowen, Shirley S., Houston.
*Boyd, Adam N., Houston.
Boykin, Jas. M., Houston.
*Braden, Albert H., Houston.
*Bradford, F. Keith, Houston.
Brady, Randle J., Houston.
Brandau, Geo. Henry, Houston.
Brandau, Geo. M., Houston.
*Brandes, Emanuel B., Houston.
Brannon, Jack G., Houston.
Brener, Lazard S., Houston.
Brener, Zidella S., Houston.
*Bressler, J. L., Houston.
Brohn, Alford J., Houston.
*Brown, Jas. A. (Mil.), Houston.
Brown, Jno. W. (Mil.), Houston.
Brown, R. Alec, Houston.
Brown, Wilbert O., Houston.
Bruce, Geo. D., Baytown.
Bruder, Wood H., Houston.
Bruhl, Chas. E., Houston.
*Bruhl, Chas. K. (Mil.), Houston.
Bruhl, Dan E., Houston.
*Brumby, Wm. M. (Hon.), Houston.
*Bryan, W. G., Houston.
Bukowski, Lucian M., Houston.
*Burg, Abner D., Houston.
*Burge, Curtis H., Houston.
Burke, Thos. W., Houston.
Burr, Harry B., Houston.
Butera, James M., Houston.
Calaway, F. Otis, Houston.
*Calhoun, C. Alsworth, Houston.
*Caplovitz, Harry, Houston.
*Carrico, Carl C., Houston.
*Carroll, Guy V., Houston.
Chandler, E. A., Houston.
*Chapman, Don W., Houston.
Chunn, Edw. K., Houston.
Clapp, Jas. Alston, Houston.
Clark, Wm. A., Houston.
*Clarke, Herndon H., Houston.
*Clarke, Jared E., Houston.
Clarkson, Ira S., Houston .
Cockrell, Jno. A., Houston.
*Cody, Claude C., Jr., Houston.
Cody, Claude C. III, Houston.
*Cohen, Raymond, Houston.
*Cole, Wm. Frank, Houston.
Coleman, Catherine E., Houston.
*Collette, Allen (Mil.), Houston.
Collier, Jas. L., Houston.
*Collins, Ray G., Houston.
Compere, Tom H., Houston.
*Conner, Edwin E., Pasadena.
Connor, Wm. Harris, Houston.
Conte, Raphael, Houston.
Coogle, C. P., Houston.
Coole, Walter A., Houston.
*Cope, R. Louis, Houston.
Corbett, L. B., Houston.
Cotlar, Nathan, Houston.
*Coulter, Wm. Wallace, Houston.
*Coulter, Wm. Wallace, Jr., Sanatorium.
Cowart, E. M., Houston.
Coxe, Lemuel F. (Mil.), Houston.
*Crapitto, Louis A., Houston.
Crawford, Elizabeth S., Houston.
*Crigler, Cecil M., Houston.
*Crocker, Ed S., Houston.
Cronin, Thos. D. (Mil.), Houston.
*Cruce, Wm. V., Houston.
Cruse, Percy R., Houston.
Cull, Herbert G., Houston.
*Cummins, Hatch W., Jr., Houston.
Cunningham, Geo. N., Houston.
*Curb, Dolph L., Houston.
Cutler, Hayden H. (Mil.), Houston.
Dailey, Jas. E., Houston.
*Daily, Louis, Houston.
*Daily, Louis, Jr., Houston.
*Daily, Ray K., Houston.
Dargan, Jos. L., Houston.
*Dashiell, Albert Mc., Houston.
David, Solomon D., Houston.
Davis, Chas. Q., Houston.
Davis, Hamlet I., Goose Creek.
Dawes, Raymond, Houston.
*Day, Geo. P., Houston.
*Denman, Peyton R., Houston.
Denzler, S. Russ, Houston.
DeVore, Neal M., Houston.
Diamond, Max M., Pasadena.
Dickson, J. Chas., Houston.
*Dipple, A. Louis, Houston.
Doak, Edmond K., Houston.
Doak, N. P., Houston.
Dodge, Wm. E. (Hon.), Houston.
*Dolph, Chancey H., Baytown.
*Donohue, Wm. M. (Mil.), Houston.
Donovan, Thos. J., Houston.
*Dornak, Franklin K., Houston.
DuBose, J. B. (Hon.), Humble.
DuCroz, J. L., Pasadena.
Duggan, Leroy B., Houston.
Duke, Herbert H., Goose Creek.
Duncan, Clara K., Houston.
Dunkerly, Allen K., Houston.
*Durham, Mylie E. (Pres.), Houston.
Durham, Mylie E., Jr., Houston.
*Durrance, Fred Y., Houston.
*Dustin, Herman E., Houston.
Edwards, Robt. A., Houston.
Ehlers, H. Jack, Houston.
Ehrhardt, Wm., Westfield.
Ekman, C. J. Ivan, Houston.
*Elles, Norma B., Houston.
*Elliott, E. E., Houston.
*Elliott, Monroe L., Houston.
*Embree, Elisha D., Houston.
Englehardt, H. A., Houston
Englehardt, Hugo T., Houston.
Entzminger, Lindell B., Houston.
Ernst, Frank J., Houston.
Estess, Berthold H., Houston.
*Farfel, Bernard, Houston.
*Faris, Arthur M., Houston.
Farrish, Geo. C., Houston.
*Fayle, Percy R., Houston.
Feagin, Horace C., Houston.
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*Fitch, Edward O., Houston.
Fleet, Carl W. (Mil.), Houston.
Fleming, Paul D., Houston.
*Flynn, Jas. G., Houston.
Flynt, Otis P., Houston.
Folsome, Clair E., Linden, N. J.
*Foote, Stephen A., Jr., Houston.
*Ford, Walter A., Houston.
*Foster, Joe B., Houston.
*Foster, John H., Houston.
Foster, Juanita E., Houston.
Frachtman, H. Julian, Houston.
*Frawley, J. T., Pasadena.
*Freundlich, Thos. W., Houston.
Frey, Clarence E., Houston.
Friend, Victor V., Houston.
Fulton, Alfred M., Houston.
Gaines, Nemo D., Hartford, Conn.
*Gamble, Jesse F., Houston.
*Gandy, D. Truett, Houston.
*Gandy, Joe R., Houston.
Gantt, Marvin A., Houston.
*Gardner, Herman L., Houston.
*Gardner, Irvin B., Houston.
Gardner, Robt. A. (Mil.), Houston.
*Garrett, Edwin E., Houston.
Gaston, John Zell, Houston.
Gates, Chas. S., Jr., Houston.
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Giessel, Julius W., Houston.
Giessel, Lotta, Houston.
*Glantzberg, Herman, Houston.
Glassman, Arthur L., Houston.
*Glen, Jno. K., Houston.
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*Goar, Everett L., Houston.
Gonzales, Angel G., Houston.
*Gooch, Frank B., Jr., Houston.
Goodloe, Noble M. (Mil.), Houston.
Goodwin, Roy T., Houston.
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*Graves, E. Ghent, Houston.
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*Greene, Jas. A., Houston.
*Greenwood, Jas., Sr., Houston.
*Greenwood, Jas., Jr., Houston.
*Greer, Alvis E., Houston.
Greer, Cecil, Houston.
Greer, V. David, Houston.
*Griffey, Edw. W., Houston.
*Griswold, C. M., Houston.
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Haden, Henry C., Houston.

Haley, John C., Houston.
Haley, S. Willard, Houston.
*Hallson, Chas. H., Houston.
Hallson, D. C. Mc., Houston.
Ham, Goldie Suttle, Houston.
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*Hamrick, Wendell H., Houston.
*Hancock, Leslie D., Houston.
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Hannon, Theo R., Houston.
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*Hargrove, R. M., Houston.
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*Harris, Herbert H., Houston.
*Harris, Jno. Wade, Houston.
Harris, T. Fred, Houston.
Harrison, Malcolmn W., Houston.
*Hartgraves, Ruth, Houston.
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*Hauser, Abe, Houston.
*Hay, Celestine Ross, Houston.
*Hay, Elliott B., Houston.
*Hayes, Herbert T., Houston.
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*Hensley, Barnes C., Houston.
*Hild, Jack R., Houston.
*Hill, Austin E., Houston.
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Hill, Jasper H., Houston.
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*Hodell, Geo. R., Houston.
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*Hoeflich, Emelia A., Houston.
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*Hollimon, Jas. H., Houston.
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Hollub, Chas. J., Houston.
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*Hooker, Lyle, Houston.
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*Huffman, M. M., Houston.
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Johnson, Seale I., Houston.
*Johnson, R. M., Houston.
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Jones, Malcolm A., Baytown.
Jones, Robt. R., San Angelo.
*Jones, Thos. R., Houston.
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*Kaminsky, Peter B., Houston.
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*Karnaky, Karl J., Houston.
*Karotkin, Lester, Houston.
*Katribe, Paul, Houston.
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*Kendall, Dean H., Houston.
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*Kennerly, Thos. P., Houston.
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*Kilgore, Morris W., Houston.
Kilgore, Newton A. (Mil.), Houston.
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*Kirkman, H. L. D. (Mil.), Houston.
Kirkpatrick, L. P. (Mil.), Houston.
*Klanke, Chas. W., Houston.
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*Knoll, Alfred F., Houston.
*Knolle, Guy E., Houston.
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*Kyle, J. Allen, Houston.
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*Lancaster, Frank H., Houston.
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Langford, Cohen H., Goose Creek.
Langston, Jno. E., Houston.
*Lapat, Wm., Houston.
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*Lechenger, Gilbert C., Houston.
*Ledbetter, Abbe A., Houston.
*Ledbetter, Paul V., Houston.
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Levin, Louis, Houston.
Levy, Moise D., Houston.
*Lewis, Arthur N., Houston.
*Lewis, Everett B., Houston.
Lewis, Leo Roy, Houston.
Leyva, Angel, Houston.
Ligon, Joseph G., Houston.
Liles, Ralph (Mil.), Houston.
Lister, Sidney M., Houston.
Littell, Milton, Houston.
Lockhart, Jessie A., Houston.
Logue, Lyle J., Houston.
*Lowe, Percy E., Houston.
*Lowe, Thos. E., Houston.
Lucas, Jas. B., Houston.
Lummis, Fred R., Houston.
Mabry, Jas. D., Houston.
*Mack, Frank A., Galena Park.
Madsen, Alva C., Houston.
Mangum, Hugh J., Houston.
Maresh, Henry R., Houston.
*Maresh, Rudolph E., Houston.
Margrave, Ross D., Houston.
Markewich, Jake, Houston.
Marshall, Reagin M., Houston.
Marshall, Wm. E., Baytown.
*Martin, Jas. R., Houston.
*Mayfield, Jack H., Houston.
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*McCulley, Jacobus D., Houston.
*McDaniel, Walter Shaw, Houston.
McGehee, Frank O., Houston.
*McHenry, Rupert Kingsley, Houston.
McIndoe, Frank W., Houston.
McKay, Haden E., Humble.
McKay, Haden E., Jr., Humble.
McKeever, Duncan C., Houston.
McKinney, Mary Ann, Houston.
McKinney, Wm. W., Houston.
McMeans, Robt. H., Houston.
*McMurrey, Allen L., Houston.
McNeill, A. S., Jr., Houston.
*McReynolds, I. S., Houston.
McRoberts, Wm. A., Houston.
McWilliams, Hamlin K., Waller.
Melton, Walter T., Houston.
Mendell, David (Mil.), Houston.
Merriman, Geo. J., Houston.
Messer, Jesse N., Houston.
*Meyer, Henry S., Houston.
Meynier, Maurice J., Jr., Houston.
*Miller, Arthur L., Houston.
Mills, Newton W., Houston.
*Mitchell, A. Lane, Houston.
Mitchner, Jas. M., Houston.
*Mock, Pressley J., LaPorte.
*Moers, Arthur E., Houston.
Moers, Edwin A., Houston.
*Mohle, Flavius D., Houston.
Molloy, Jas. P., Jr., Houston.
*Montgomery, Chas. F., Houston.
Moody, Betty, Houston.
Moody, Irvin W., Houston.
Mooney, Ern C., Houston.
*Moore, Jno. T. (EMR), Houston.
Moorhead, Wm. H., Houston.
*Morse, Walter S., Houston.
*Motheral, Jefferson D., Katy.
*Moursund, Walter H., Houston.
Much, Jos. C. (Mil.), Houston.
Mullen, Jos. A. (Hon.), Houston.
Myers, Claude D., Houston.
Myers, Leonard A., Houston.
Mynatt, Arthur J. (Hon.), Houston.
*Nester, Chas. R., Houston.
*O'Heeron, Michael K., Houston.
Ohlhausen, S. G., Houston.
*Oldham, Dudley Y., Houston.
Oliver, Jno. Stanley, Houston.
Oliver, J. T., Houston.
Oliver, Wm. D., Galena Park.
*Orman, McDonald, Houston.
*Orr, Guy H., Houston.
Osborne, Clarence F., Pasadena.
Osmun, Paul M., Seattle, Wash.
Overgaard, Anders P., Houston.
*Owen, A. Geo., Houston.
Owens, Jno. B., Houston.
Page, Jos. Herbert (Mil.), Houston.
Panzarella, Carlo J., Humble.
Parish, Irving, Houston.
*Park, Jas., H., Jr., Houston.
Parr, Luther H., Houston.
Parrish, Frank F., Jr. (Mil.), Houston.
Parsons, A. M., Houston.
*Paton, Donald M., Houston.
*Patrick, Ralph C., Houston.
*Patteson, James L., Houston.
Patterson, Robt. T., Houston.
Pawelek, Isidor L., Houston.
Pawelek, Louis G., Houston.
Perdue, Geo. W., Houston.
Peters, Isador D., Houston.
*Petersen, Henry A., Houston.
Peterson, Carl A., Houston.
*Petri, Karin A., Houston.
Phillips, Elliott S., Houston.
Phillips, Leon, Houston.
*Phillips, Jno. R., Houston.
*Phillips, Paul G., Houston.
Pickard, Alpha C., Houston.
*Pipkin, Robert W., Baytown.
*Pittman, Jas. E., Houston.
Podesta, Louis N., Houston.
Pope, A. E. C., Crosby.
Potter, Leo E. (Mil.), Houston.
*Potts, Charles R., Houston.
*Powell, Elizabeth B., Houston.
*Powell, Norborne B., Houston.
*Poyner, Herbert F., Houston.
*Pratt, Willard M., Houston.
*Prince, Homer E., Houston.
Pritchett, I. E., Houston.
Pugsley, Cornelius, Jr., Houston.
*Pulliam, Lawrence T., Houston.
Pulliam, Seely T., Houston.
*Putnam, Lincoln F., Houston.
Qualtrough, Walter F., Houston.
Rader, Jno. F., Houston.
Ralston, Wallace W., Houston.
*Ramsey, Wm. E., Houston.
*Raney, Lovel W., Houston.
*Ray, John W., Houston.
*Red, Wm. S., Jr., Houston.
Reece, Chas. D., Houston.
Reed, Roy W. (Mil.), Houston.
Reinke, Robt. T., Baytown.
*Renfrow, W. Frank, Houston.
Rives, Hugh F., Houston.
Roberts, Jas. A., Jr. (Mil.), Houston.
*Robertson, Robt. C. L., Houston.
Robey, Grace Lucile, Houston.
Robbins, E. Freeman, Houston.
Robbins, Frank, Goose Creek.
*Robinett, Jas. B., Jr., Houston.
Robins, Bill, Houston.
Robinson, Hampton C., Houston.
*Robinson, J. M., Houston.
Rollins, Wiley J., Houston.
*Royce, Thos. L., Houston.
Ruiz, Jno. J., Houston.
Rumph, Quah (Mil.), Houston.
*Rushing, Jno. B., Houston.
*Russell, Thos. G., Houston.
*Ryan, Bert M., Houston.
Sacco, Allen C., Houston.
Salerno, Jos. P. (Mil.), Houston.
Salinger, Alfons, Houston.
Salley, Calvin W., New Orleans, La.
*Salmon, Geo. W., Houston.
Sanborn, Clifton E., Jr., Redlands, Calif.
*Sanders, Chas. B., Houston.
Sanders, Zal H., Houston.
*Sanderson, Thos. A., Houston.
Sandlin, Jas. W., Beaumont.
Sappington, H. O., Baytown.
Scardino, Peter H., Houston.
Schaffer, Elliott N., Houston.
Schaffer, Samuel S. (Mil.), Houston.
Schaffer, Helen G., Houston.
*Schilling, Jno. G., Houston.
Schnur, Sidney, Houston.
Schoepfer, Rene F., Houston.
*Schultz, Jacob F., Houston.
Scott, Dan W., Houston.
*Scull, Alvis Joe, Houston.
*Seale, Everett R., Houston.
Sears, Ernest S., Houston.
Secrest, P. G., Jr. (Mil.), Houston.
*Seibold, Geo. J., Houston.
Selders, Raymond E., Houston.
Sengelmann, Wilbur A., Houston.
*Shaffer, Carl F., Houston.
*Shaw, Edw. N., Houston.
*Shearer, Thos. P., Houston.
Sherrill, E. A., Houston.
Sherrill, E. A., Jr. (Mil.), Houston.
Sherrill, Lloyd H., Houston.
Shirley, Carl W. (Mil.), Houston.
Singleton, Paul C. A., Houston.
Skogland, Jno. E., Houston.
*Slataper, Felician J., Houston.
Smith, Burt B., Houston.
Smith, Benjamin F., Houston.
Smith, Clifford T., Houston.
Smith, Edw. T., Houston.
Smith, Fred B. (Mil.), Houston.

*Smith, J. Murray, Houston.
Smith, Wm. Marshall, Houston.
*Snow, Wm. J., Houston.
Spencer, Walter C. E., Houston.
Spezia, Jos. L., Houston.
*Spiller, J. B., Houston.
*Spivak, Louis J., Houston.
Spurlock, G. H., Houston.
Stackhouse, Howard, Jr., Houston.
*Stalnaker, Paul R., Houston.
Sterling, Russell R., Houston.
Stevenson, Wilmer M., Houston.
*Stewart, Marcus J., Houston.
Stock, Geo. E., Jr., Houston.
*Stokes, Merl B., Houston.
Stone, Francis E., Houston.
*Stork, Walter J. (Mil.), Houston.
*Stough, Jno. T., Houston.
Straushun, Mat Frank (Mil.), Houston.
*Strassmann, Erwin O., Houston.
*Strozier, W. M., Houston.
Stucki, Jas. M., Houston.
Swetland, Douglas R., Houston.
Synnott, Thos. G., Houston.
Tackaberry, Arthur L. W., Houston.
Talley, Arthur T., Houston.
*Talley, Arthur T., Jr., Houston.
*Talley, Elizabeth D., Houston.
*Taubenhaus, Leon J., Houston.
*Theroit, Jos. Roy, Jr., Houston.
Thoma, Earl W., Houston.
Thomas, Charles, Houston.
Thomas, Geo. B., Houston.
Thompson, Benjamin D., Houston.
Thorn, S. W., Houston.
Thorning, W. B., Jr. (Mil.), Houston.
*Trible, Jno. M., Houston.
*Truitt, Jas. J., Houston.
Tucker, J. Norris (Mil.), Houston.
Turboff, Sidney W., Houston.
*Turner, B. Weems, Houston.
Turner, Claude G., Houston.
Tusa, Theo S., Houston.
*Tuttle, L. L. D., Houston.
Ulert, Izaak A., Houston.
Vanzant, B. T., Houston.
Vanzant, Thos. J. (Mil.), Houston.
Vaughn, Luther M., Rochester, Minn.
Veatch, Everett P., Pasadena.
Vick, J. Louise, Houston.
Von Pohle, Kenneth C., Houston.
Wachsman, David V., Houston.
*Waldron, Geo. W., Houston.
*Walker, Jos. D., Houston.
Wall, Herman A., Jr., Houston.
*Wall, Jno. A., Houston.
*Wallace, Stuart A., Houston.
Ward, Thos. E., Houston.
Warner, Clyde M., Houston.
Warner, Lucien M., Houston.
*Waters, Charles R., Highlands.
*Waterman, Jno. H., Houston.
Watson, James E., Jr., Houston.
Watson, Price T. (Mil.), Houston.
Wedin, Paul H., Houston.
Weil, Sol B., Jr., Houston.
Weisiger, Ross W. (Mil.), Houston.
*Welsh, Hugh C., Houston.
Westmoreland, Jas. P., Houston.
Westover, Harry M., Houston.
Whitsitt, Jas. J., Houston.
Wible, D. Jordan, Houston.
Wier, Warren M., Houston.
Wiesenthal, Jos., Houston.
*Wigby, Palmer E., Houston.
*Wild, Wm. B., Pasadena.
*Wilkerson, B. J., Houston.
*Wilkerson, Edw. A., Houston.
Williford, Louis E., Houston.
Williams, Wm. O., Houston.
Willis, Seward H., Houston.
*Wilson, Carl S., Houston.
Windrow, Nuel C., Jr. (Mil.), Houston.
Wither, Ben T., Houston.
Withers, Henry Wm. (Mil.), Houston.
*Wolf, Edw. Trowbridge, Houston.
Wood, Martha A., Houston.
Wootters, John H., Houston.
Worth, Thos. C., Houston.
Wright, Elva A. (Hon.), Houston.
Wright, Ernest, Houston.
*York, Byron P., Houston.
Young, Carl B., Houston.
*Youngblood, J. C., Houston.
Zanek, Otto L., Boston, Mass.
Zarr, L. Lynn, Houston.
*Zax, Emile, Houston.
Zeis, Leander B., Houston.
Zepeda, Rudolph F., Houston.
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Jones, Wm. T., Huntsville.
McKay, James A., Madisonville.
*Morris, James E., Madisonville.
Veazey, Wm. B. (Sec'y), Huntsville.

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Hasskarl, Walter F., Brenham.
Hodde, Fred H., Brenham.
Hodde, Herman O., Brenham.
Knolle, Roger E., Brenham.
Knolle, Waldo A., Brenham.
*Kusch, G. A. L. (dead), Gay Hill.
Schoenvogel, Otto F., Brenham.
*Southern, Chas. E., Burton.
Steinback, Herbert L., Brenham.

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Clements, J. C. (Mil.), Lufkin.
Clements, Peyton C., Lufkin.
Dale, Jno. R., Jr. (Pres.), Diboll
Denman, Byford H., Lufkin.
*Denman, Linwood H., Lufkin.
Estep, Marshall A., Lufkin.
Evans, C. W., Jr., Lufkin.
Forrest, R. B., Huntington.
*Gibson, Mitchell O., Lufkin.
Gandy, Orren P., Lufkin.
Harrington, E. R., Huntington.
*Klein, Jas. C., Lufkin.
Mathews, R. L. (Hon.), Lufkin.
Medford, Ulen Gail, Lufkin.
Ostendorf, W. A. (Mil.), Lufkin.
Peebles, Felix, Jr., Lufkin.
*Sweatland, A. E., Lufkin.
*Taylor, Robt. W. (Sec'y), Lufkin.
Taylor, Thaddeus A., Lufkin.
Tinkle, Lassiter T., Lufkin.
Wade, Jack H., Lufkin.

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*Barclay, Watt, Woodville.
Beazley, W. H. (Sec'y), Silsbee.
Cline, W. B., Woodville.
Darby, T. O., Sour Lake.
Fowler, I. R., Silsbee.
Knight, John A., Beaumont.
Lockey, Robt. P., Voth.
Mann, J. S., Colmesneil.
*Poshataske, W. J. (Pres.), Silsbee.
*Roark, A. W., Saratoga.
Shivers, John F., Woodville.
Tate, R. A., Kountze.
Tennison, Geo. Davison, Silsbee.

JASPER-NEWTON COUNTIES MEDICAL SOCIETY

Dickerson, Joe H. (Mil.), Jasper.
Freeman, E. S., Jasper.
Graham, Gideon, Newton.
Graham, G. Mason (Sec'y), Bessmay.
Hall, Henry S., Newton.
Hardy, Hugh W., Jasper.
Kelly, W. R., Jasper.
McCreight, W. F., Kirbyville.
McGrath, J. J., Jasper.
Monroe, Myrick L., Jasper.
Richardson, Arthur J., Jasper.
Richardson, Arthur J., Jr., Jasper.
Seale, Jas. N., (Pres.), Jasper.
Wilson, S. G., Pineland.
Worthy, W. R., Call.

JEFFERSON COUNTY MEDICAL SOCIETY

Alexander, Hugh E., Beaumont.
Allamon, Emmett L., Beaumont.
Allison, F. Peel (Mil.), Beaumont.
Autrey, A. R., Port Arthur.
*Barr, Richard E., Beaumont.
Best, Harvey T., Port Arthur.
Bevil, Harold H., Beaumont.
Bevil, Harold Grady, Beaumont.
Bevil, Jno. R., Beaumont.
Bevil, Lamar C., Beaumont.
Beyt, Frank J., Port Arthur.
Bialkin, Geo., Port Arthur.
Blum, S. L., Beaumont.
Boring, C. W., Port Arthur.
Brandau, W. H., Beaumont.
*Brown, W. D., Beaumont.
Bybee, Joe A., Beaumont.
*Byram, Dan Heard, Port Arthur.
Byrd, Lee Roy, Jr. (Sec'y), Port Arthur.
Carroll, Roland B., Port Arthur.
Carter, Jno. H., Beaumont.
*Carter, Louian C., Port Arthur.
*Chaisson, Mary P., Beaumont.
Chunn, B. D., Beaumont.
Colby, Fred W. C., Beaumont.
Covode, Wm. M. (Mil.), Port Arthur.
Crager, J. C., Beaumont.
Crumpler, W. E., Jr., Port Arthur.
*Cunningham, M. A., Beaumont.
Currey, Dwight E. (Mil.), Port Arthur.
Darwin, P. S., Beaumont.
Davison, B. Howard, Port Arthur.
*Duren, Norman, Beaumont.
Eisenstadt, H. B., Port Arthur.
*Elster, Benjamin B., Port Arthur.
*Engledow, R. H., Beaumont.
*English, Dudley M., Beaumont.
*Fears, T. A., Beaumont.
*Ferguson, Edward C., Beaumont.
Fertitta, Julian J., Beaumont.
Fett, Bennie J., Port Arthur.
Fortney, Paul N., Beaumont.
Frank, S. Rosa, Beaumont.
Fulbright, Carl W., Port Arthur.
*Furey, Ellen D., Beaumont.
Fuselier, J. D., Port Arthur.
Gardner, John N., Beaumont.
Goldblum, Harvey H., Port Arthur.
*Graber, W. J. (Mil.), Beaumont.
Granata, Samuel V., Beaumont.
*Greenberg, Phillip B., Beaumont.
Hager, Dale C., Beaumont.
Harlan, H. D., Beaumont.
*Harper, J. Y., Port Arthur.
*Hart, Frank B., Beaumont.
*Hart, Jno. A., Beaumont.
*Heare, Louis C., Port Arthur.
Hendry, C. H., Beaumont.
Hines, J. C., Nederland.
Hosen, Harris, Port Arthur.
Jackson, J. M., Port Arthur.
Jacobson, Harry, Beaumont.
Jones, S. Ross (Hon.), Waco.
Jones, Thos. R. (Mil.), Beaumont.
Kaplan, Hyman J., Beaumont.
Killingsworth, W. P., Port Arthur.
Knight, Max J., Port Arthur.
Kuhlman, Frederick Y., Port Arthur.
*Ledbetter, L. H., Beaumont.
Lewis, Seab J., Beaumont.
Lightfoot, W. D., Beaumont.
Lindsey, Eugene H., Beaumont.
Loewenstein, Jos. M., Port Arthur.
*Lombardo, R. T., Beaumont.
Long, James W., Port Arthur.
Lyons, Sam B., Beaumont.
Makins, James, Port Arthur.

Mann, D. A., Beaumont.
*Martin, J. D., Beaumont.
*Martin, T. W., Port Arthur.
*Matlock, Thos. B., Port Arthur.
*McFadden, Irma M., Port Arthur.
McRee, Edgar C., Port Arthur.
McRee, Walter E., Jr., Port Arthur.
*Meyer, Paul R., Port Arthur.
*Middleton, W. C., Beaumont.
*Mills, E. D., Beaumont.
*Mitchell, Theo. Curtis, Beaumont.
Mixson, Harold J., Beaumont.
*Newton, W. A., Beaumont.
Nibling, Boyd (Mil.), Beaumont.
Orrill, R. Ray, Port Arthur.
Pace, Bedford F., Nederland.
Painton, Clifford E., Port Arthur.
Pecora, Tony L., Beaumont.
Pentecost, Chas. L., Beaumont.
Petit, Paul Thurlow, Beaumont.
Pierson, Rogers, Beaumont.
Pitre, Roy Paul (Mil.), Port Arthur.
*Powell, L. C., Beaumont.
Pruit, L. T., Beaumont.
Raine, M. F., Port Arthur.
Raines, Jas. M., Port Arthur.
Record, Joe, Beaumont.
*Robert, Wm. Pierre, Beaumont.
Rowe, Kit W., Beaumont.
Sappington, T. B., Port Arthur.
Serafino, L. C., Beaumont.
Shaddock, C. B. (Mil.), Beaumont.
Simpson, Rufus K., Beaumont.
*Sladczyk, George (Pres.), Port Arthur.
*Smith, Wm. A., Beaumont.
Solis, G. R., Port Arthur.
*Stephenson, G. Bruce (Mil.), Beaumont.
Stevens, Robert B., Beaumont.
Stoeltje, Joe, Beaumont.
Stroble, Rosser J., Port Neches.
Suehs, M. E., Jr., Beaumont.
*Sutton, F. W., Beaumont.
Tatum, W. E., Beaumont.
*Todd, Charles H., Jr., Beaumont.
Toomin, Emanual, Beaumont.
*Torbett, Jno. Walter, Jr., Beaumont.
*Tyndall, Thos. M., Beaumont.
Tyner, Furman H. (Mil.), Port Arthur.
Vaughn, B. H., Port Arthur.
*Vaughn, E. W., Port Arthur.
*Walker, Taylor C., Beaumont.
*Wallace, Wm. G., Beaumont.
Ward, E. G., Beaumont.
Welch, J. G., Port Neches.
White, C. M., Beaumont.
White, J. Milton, Port Arthur.
*White, John M., Jr., Port Arthur.
Wier, D. S. (Hon.), Beaumont.
Wier, Stuart T., Beaumont.
Williams, F. G., Beaumont.
*Williford, H. B., Beaumont.
*Willoughby, Russell C., Groves.
Wood, Byron W., Port Arthur.
Woodall, J. B., Port Arthur.
Woodward, John F., Jr., Beaumont.
*Young, Isaac T., Port Arthur.
Young, T. W., Jr., Port Arthur.

LIBERTY-CHAMBERS COUNTIES MEDICAL SOCIETY

Bellamy, Richard C., Daisetta.
Bevil, Jack, Hull.
Black, Roy C., Cleveland.
Bridges, Wm. H., Goose Creek.
*Carr, K. K., Devers.
Clements, E. B., Cleveland.
Davidson, Eli, Liberty.
Delaney, A. L., Liberty.
Fahring, Geo. H., Anahuac.
*Griffin, Frank S. (Pres.), Liberty.
Jordan, B. L., Daisetta.
Leggett, Walter, Cleveland.
Richter, Ernest R. (Sec'y), Dayton.
*Shearer, A. R., Mont Belvieu.
Sykes, Everett W., Anahuac.
Tadlock, J. T., Dayton.
Tucker, Eli J., Liberty.

NACOGDOCHES COUNTY MEDICAL SOCIETY

Barham, Geo. S., Nacogdoches.
*Beall, Jas. Frank, Nacogdoches.
Ferguson, Sarah (Taylor), Nacogdoches.
Fuller, J. L., Garrison.
McKinney, Edgar P., Nacogdoches.
Middlebrook, Geo. F., Nacogdoches.
*Nelson, A. Langston (Pres.), Nacogdoches.
Neuville, Carroll F., Nacgodoches.
Payne, C. M., Nacogdoches.
Rulfs, Carl Henry, San Augustine.
Smith, Clarence T., Nacogdoches.
Taylor, Jas. Criffin, Nacogdoches.
Tucker, Felix R., Nacogdoches.
Tucker, F. Henry (Sec'y), Nacogdoches.
*Tucker, Stephen B., Nacogdoches.

ORANGE COUNTY MEDICAL SOCIETY

Anderson, Roland B. (Mil.), Camp Wallace.
Bennett, David, Orange.
Buttram, C. A., Santa Rosa, Calif.
Covington, C. M., Orange.
*Hawkins, Eugene W. (Pres.), Orange.
*Key, Harry H., Orange.
Pearce, H. Wynne, Orange.
Peters, Leo J., Orange.
Phillips, C. E. (Hon.), Orange.
Schofield, Elmer C., Orange.
Seastrunk, Oliver C., Orange.
Shaddock, C. B., Orange.
Smith, Jack V., Orange.
Swickard, Geo. Y. (Sec'y), Orange.
Thompson, L. O., Orange.
*Woolley, T. O., Orange.

PANOLA COUNTY MEDICAL SOCIETY

Ashby, Joe M, Carthage.
Baker, Chas. D. (Sec'y), Carthage.
Daniels, DuBose B., Carthage.
Daniels, Zack L., Gary.
Hooker, Lynn C., Carthage.
Hull, Chas. F. (Pres.), Carthage.
*Kuykendall, H. D., Carthage.

RUSK COUNTY MEDICAL SOCIETY

Ahney, Thos. B., Overton.
Allen, J. C., Henderson.
Birdwell, J. A., Overton.
Boswell, Wm. E., Henderson.
Dawson, C. A. (Sec'y), Minden.
Deason, Floyd S., Henderson.
Deason, Giles A., Henderson.
Heilegman, H., Overton.
Hicks, Oliver B., Henderson.
Hilburn, Lynn, Henderson.
Lall, Shiam, Tulsa, Okla.
McNabb, Jos. F., Newton, Mass.
Pluenneke, Perry C., Overton.
Ross, Griff, Mt. Enterprise.
Ross, Jesse E., Henderson.
Sadler, Jos. G., Henderson.
Shaw, R. F., Henderson.
Shipp, L. M., Henderson.
Suehs, Herbert A., Henderson.
Watkins, J. E. (Pres.), Henderson.
Wolfe, Alfred S., Henderson.

SHELBY-SAN AUGUSTINE-SABINE COUNTIES MEDICAL SOCIETY

Brake, Ira F., San Augustine.
Copeland, Andrew G., Timpson.
Hurst, Thos. L., Center.
Oates, Lareid S., Center.
Watson, Chester A., Hemphill.
*Warren, William H. (Sec'y), Center.
Warren, Walter M., Center.
Warren, Wm. S., Center.
Windham, John H., Shelbyville.
Windham, Wm. C. (Pres.), Center.

ELEVENTH OR EASTERN DISTRICT

Dr. J. M. Travis, Jacksonville, Councilor.

ANDERSON-HOUSTON-LEON COUNTIES MEDICAL SOCIETY

*Barclay, Sam D., Crockett.
*Bell, Robt. H., Palestine.
Bing, Roland E., Oakwood.
*Butler, Chas. W., Jr., Crockett.
Carter, Jas. W., Palestine.
*Dean, Jno. L., Jr. (Sec'y), Crockett.
Davis, W. E., Elkhart.
Farmer, R. A., Grapeland.
Felder, Fred E., Palestine.
Funderburk, Wm. O., Palestine.
Hathcock, Alfred L., Palestine.
Haverlah, Harry A., Palestine.
Hester, Nell M., Buffalo.
Humphries, Jno. T., Palestine.
Hunter, Ripley H. (Pres.), Palestine.
Hunter, Rush Q., Palestine.
Joyce, Claude D., Jr., Palestine.
Kennedy, Sam, Grapeland.
King, Marion A., Frankston.
McLeod, Robt. H., Palestine.
Moss, Geo. H., Frankston.
Murphy, Jos. G., Palestine.
Powell, E. P., Centerville.
Rogers, Joe, Normangee.
Scarborough, E. H., Poyner.
Speegle, Andrew A., Palestine.
Stokes, Paul B., Crockett.
Tenney, Leighton P., Buffalo.
*Trice, Leroy, Palestine.
Wages, Allen D., Palestine.
Wootters, Jno. S., Crockett.

CHEROKEE COUNTY MEDICAL SOCIETY

Adams, Clyde, Rusk.
Bone, J. N., Jacksonville.
Boyd, Jas. T., Jacksonville.
Burnett, E. W., Rusk.
Bullion, Chas. F., Dallas.
Cobble, Thos. H. (Sec'y), Rusk.
Davenport, Harbert, Jr., Houston.
*DuBose, J. L., Wells.
Evans, Chas. W., Apple Springs.
Gray, D. F., Houston.
Greenwood, J. T., Ponta.
Hall, Robt. L., Rusk.
*Hanretta, A. T., Austin.
Hilliard, Geo. M., Jr., Jacksonville.
Johnson, Jno. F., Rusk.
Jones, Pearl E., Ponta.
Kuykendall, M. J., Rusk.
Lamb, Marvin (Pres.), Jacksonville.
McDonald, W. A., Alto.
*McDougle, Jno. B., Jacksonville.
Moseley, E. M., Rusk.
*Scarbrough, Jas. S., Rusk.
*Sory, W. H., Jacksonville.
Stripling, C. H., Jacksonville.
Travis, John, Jacksonville.
*Travis, J. M., Jacksonville.
*Travis, L. L., Jacksonville.
Travis, R. T., Jacksonville.
*Urban, Kay B., Rusk.
Wheeler, M. S., Austin.
Whiteside, Wm. A., Rusk.

FREESTONE COUNTY MEDICAL SOCIETY

Bonner, Leslie L. (Sec'y), Fairfield.
Gage, Maurice (Pres.), Teague.
Harrison, Wm. P., Teague.
Headlee, Emory V., Teague.
Sneed, Wm. N., Fairfield.

HENDERSON COUNTY MEDICAL SOCIETY

Baugh, Joseph F., Chandler.
Cockerell, Lonnie L., Athens.
Geddie, Nolan D., Athens.
Henderson, Roy E. (Pres.), Athens.
Hodge, Robert H., Athens.
Horton, Arthur C., Brownsboro.
Kilman, Prather T., Malakoff.
Price, Don (Sec'y), Athens.
Webster, John K. (Hon), Athens.

SMITH COUNTY MEDICAL SOCIETY

Bailey, Wm. Marvin (Sec'y), Tyler.
Bell, Geo. G., Tyler.
*Birdwell, Jas. W. (Mil.), Tyler.
Bradford, Sidney Wm., Tyler.
Brown, Glynne, Tyler.
Bryant, W. Howard, Tyler.
Bundy, David T., Tyler.
Cain, Wm. Roy, Tyler.
*Caldwell, Elbert H., Tyler.
Clawater, E. W., Tyler.
Cooke, Lane B. (Mil.), Tyler.
Dickson, Jas. R., Arp.
Eliscu, Juliette M., Tyler.
Faust, John J., Tyler.
Gibson, Jesse W., Lindale.
Goldfeder, Jesse (Mil), Tyler.
*Jarmon, Thomas M., Tyler.
Marshall, Robert L., Tyler.
*McDonald, Conrad C., Tyler.
McMillan, Bruce, Arp.
Mitchell, John H., Tyler.
Moore, Masters H., Tyler.
Neill, Lex T. (Pres.), Tyler.
Page, Roy Lee, Tyler.
Pope, Irvin, Jr., Tyler.
Rhine, Leland R., Tyler.
Rice, E. D., Tyler.
Ross, Wm. Rutledge, Tyler.
*Sehested, Herman C. (Mil.), Tyler.
Shirley, Thos. Clayton, Tyler.
Smith, Jno. C., Winona.
Stanley, Mildred, Tyler.
Thompson, Orion, Tyler.
Vaughn, Edgar H., Tyler.
Vaughn, Jas. M. (Mil.), Tyler.
Walker, U. G. M., Flint.
*Wilcox, Melvin R., Tyler.
*Willingham, Chas. E., Tyler.
*Windham, Lynn B., Tyler.

Woldert, Albert, Tyler.
*Young, Cuthbert B., Tyler.

TWELFTH OR CENTRAL DISTRICT

Dr. G. V. Brindley, Temple, Councilor.

BELL COUNTY MEDICAL SOCIETY

Alsup, Ace H., Temple.
Anderson, Harold B., Temple.
Archer, Thos. J., Austin.
Bassel, Paul M., Temple.
Bauman, Jno. E., Temple.
Bohmfalk, Stanley W., Temple.
Bradfield, Eldon O., Temple.
*Brindley, Geo. V., Temple.
Bunkley, Thelbert F., Temple.
Burow, F. Paul., Killeen.
Caskey, Chas. R., Colorado Springs, Colo.
Chernosky, Wm. A., Temple.
Christian, Jno. J., Temple.
Cooke, Mildred L., New York.
Curtis, Raleigh R., Temple.
*Curtis, Richard C., Temple.
*Debord, Bert, Jr., Temple.
Eanes, David F. S. (Mil.), Little Rock, Ark.
Flett, David M., Temple.
Fowler, Joe A., Killeen.
Gillespie, Chas. H., Temple.
Gober, Olin B. (Sec'y), Temple.
Greenwood, Jos. H., Temple.
Hammond, Fred M., Temple.
*Harlan, Rudolph K., Temple.
Howell, Floyd W., Temple.
Jenkins, Jesse G., Temple.
Kilman, Jos R., Temple.
Knight, Lee (Hon.), Temple.
*Longmire, Victor M., Temple.
Lyday, Victor I., Temple.
*Macey, Harry B., Temple.
*Maxwell, Walter J., Jr., Temple.
McCelvey, Jno. S., Temple.
McDavitt, Bertha S., Temple.
*McKay, Edward D., Temple.
Metzger, Wm. Raymond, Temple.
Moon, Arthur E., Temple.
Moreton, Robt. D., Temple.
*Phillips, Charles, Temple.
*Pittman, J. W., Belton.
*Pollok, Lewis W., Temple.
*Potter, Claudia, Temple.
*Powell, Wm. N., Temple.
Ramey, Paul M., Temple.
Robinson, Jas. E., Temple.
Rodarte, Jose G., Temple.
*Scott, Arthur C., Jr., Temple.
Seedorf, Everett E., Temple.
Sewell, Harvey W., Belton.
*Sewell, Julian G., Belton.
Sherwood, Marcel W., Temple.
Shibler, Samuel W., Temple.
Simmons, Vincent J., Temple.
Simpson, Chas. M., Temple.
Smith, Robert N., Jr., Temple.
Speed, Terrell, Temple.
*Stevenson, Clyde A., Temple.
Stuart, Lawrence D., Temple.
Talley, Lewis R., Temple.
*Veirs, Everett R., Temple.
Wiedeman, Andrew E. (Pres.), Temple.
*Winston, Jno. R., Temple.
Wolf, A. Ford, Temple.
*Woodson, Warren Burbank, Temple.

BOSQUE COUNTY MEDICAL SOCIETY

Archer, Jas. T., Jr. (Pres.), Meridian.
Blankenship, W. W., Mosheim.
Calhoun, James S., Walnut Springs.
Cate, Clifton C., Morgan.
*Holt, Russell D., Jr., Meridian.
Holt, Russell D., Sr., Cranfills Gap.
Goodall, Van D., Clifton.
*Long, Austin M., Valley Mills.
Murray, Jas. A., Walnut Springs.
Pike, Arthur N., Iredell.
*Witcher, Seth L. (Sec'y), Clifton.

BRAZOS-ROBERTSON COUNTIES MEDICAL SOCIETY

Andres, Dwight W., College Station.
Boguskie, Wm. M., Hearne.
Cummings, H. W. (Hon.), Hearne.
Ehlinger, Rancier B., Bryan.
Grant, R. B., Jr. (Sec'y), Bryan.
*Harrison, R. H., Jr. (Pres.), Bryan.
*Holt, Ernest E., College Station.
Hunnicutt, Robt. J., Bryan.
*Marsh, John E., College Station.
McGill, A. G., Bryan.
Parker, Wm. S., Calvert.
Perry, Jas. S., Bryan.
*Richardson, S. C., Bryan.
Sanders, J. G., Bremond.
Searcy, R. M., Bryan.
Searcy, Thos. A., Hearne.
Smith, Jas. A., Hearne.
Smith, R. L., Bryan.
Taylor, W. C., Jr., Calvert.
Walton, Thos. T., Bryan.
Walton, Thos. O., Jr (Mil.), Bryan.
Wilkerson, Lonnie O., Bryan.
Woodard, Paul A., Bryan.

CORYELL COUNTY MEDICAL SOCIETY

Brown, John T., Gatesville.
Hall, T. M., Gatesville.
Hamilton, J. H., Gatesville.
Jones, Dean B., Gatesville.
Jones, Kermit R. (Sec'y), Gatesville.
Lowrey, E. E., Gatesville.
Lowrey, M. W. (Pres.). Gatesville.

ERATH-HOOD-SOMERVELL COUNTIES MEDICAL SOCIETY

Barekman, Wm. Harold, Stephenville.
*Bryan, T. F., Dublin.
Cragwall, A. O. (Pres.), Stephenville.
Currie, A. B., Groveton.
Hanna, J. J., Glen Rose.
Langford, W. L., Hamilton.
Lankford, A. E., Stephenville.
Mulloy, J. J., Stephenville.
Pate, Joe J., Dublin.
Scherman, Albert J., Stephenville.
Spears, Clarence W., Oak Hill, Ohio.
Terrell, J. C., Stephenville.
Terrell, Vance (Sec'y), Stephenville.

FALLS COUNTY MEDICAL SOCIETY

Allen, Walter B., Marlin.
Avent, Benjamin M., Rosebud.
*Barnett, John B., Marlin.
Barnett, John H., Marlin.
*Bennett, A. C. (Pres.), Marlin.
*Brown, J. M., Marlin.
*Buie, Neil D., Sr., Marlin.
Buie, Neil D., Jr. (Mil.), Marlin.
Collier, Joel I., Marlin.
Cornwell, Charles (Mil.), Marlin.
Curry, Hardy P., Marlin.
*Davison, Milton A., Marlin.
Garrett, Henry S., Marlin.
Glass, Thomas G., Marlin.
*Green, John E., Austin.
Hampshire, George H., Marlin.
Hutchings, Edgar P., Marlin.
Hutchins, S. P. R. (Mil.), Marlin.
Jansing, Bernard A., Lott, Rt. 3.
Munger, S. S. (Hon.), Marlin.
Price, Chester A., Chicago
*Smith, Howard O., Marlin.
Smith, Walter S., Marlin.
Swepston, Happy J., Rosebud.
Torbett, J. W., Sr. (Sec'y), Marlin.
Von Tobel, Albert E., Marlin.

HAMILTON COUNTY MEDICAL SOCIETY

Cleveland, Chas. C., Hamilton.
Hedges, Homer V., Hico.
Kennedy, Francis P., Carlton.
Knight, Jas. B., Hamilton.
Kooken, Robt. A. (Sec'y), Hamilton.
West, Robert C. (Pres.), Hamilton.

HILL COUNTY MEDICAL SOCIETY

Arledge, William I., Hillsboro.
Barnes, Livingston, Hubbard.
Barnett, Thomas R., Hillsboro.
Beskow, Richard N., Hillsboro.
Boyd, James E. (Pres.), Hillsboro.
Buie, James S., Mertens.
Campbell, Clark C., Itasca.
Foster, Dee R., Itasca.
Garrett, Charles A. (Sec'y), Hillsboro.
Jenkins, Gaines H., Bynum.
Mahaffey, Howard A., Hillsboro.
McPherson, A. B. (Hon.), Lovelace via Hillsboro.
McPherson, Garland, Hillsboro.
Morris, Thomas M., Mt. Calm.
Sammons, Howard P., Hubbard.
Sims, Foster D., Rusk.
*Smith, Benjamin C., Hillsboro.
Smith, Nellins C., Hillsboro.
Treat, W. F. (Hon.), Whitney.
Zacharias, Otis G., Topeka, Kans.

JOHNSON COUNTY MEDICAL SOCIETY

Anderson, C. C., Venus.
*Ball, W. P., Cleburne.
Cooks, C. C., Cleburne.
Durrill, Everett L., Cleburne.
Edgar, C. L., Cleburne.
Jowell, C. C., Cleburne.
Kimbro, Robt. W., Cleburne.
Knox, M. T., Cleburne.
Little, J. G. (Mil.), Cleburne.
Pickens, Jay W., Cleburne.
Washburn, W. R., Cleburne.
Whitehouse, Wm. R. (Sec'y), Cleburne.
Yater, R. E. Lee (Pres.), Cleburne.
Yater, T. F., Cleburne.

LIMESTONE COUNTY MEDICAL SOCIETY

*Brown, Marion M. (Sec'y), Mexia.
Carrington, W. L., Mexia.
Christoffer, O. T. (Pres.), Mexia.
Cox, Stanley, Groesbeck.
Cromeans, Randall E., Mexia.
Edgar, Cecil C., Mexia.
McKenzie, Casimir P., Mexia.

McLENNAN COUNTY MEDICAL SOCIETY

Aide, Lewis G., Bellmead.
*Alexander, Boyd D., Waco.
Alexander, R. B., Waco.
*Anspach, Harold M., Waco.
*Atkins, N. M., Waco.
*Aynesworth, Horace T. (Pres.), Waco.
*Aynesworth, M. B., Waco.
Baker, Mark D., Waco.
*Barnes, Maurice C., Waco.
Bell, R. B., Waco.
Bradford, J. C., Mart.
Brannon, E. P., Waco.
Brooks, C. H., Waco.
Bullard, Ray E., Waco.
*Burgess, Jno. L., Waco.
*Carlisle, M. C., Waco.
*Catto, Chas. G., Waco.
Coffelt, Ralph L., Waco.
Collins, C. T., Waco.
*Collins, Chas. E., Waco.
*Connally, H. F., Waco.
*Connally, H. Frank, Jr., Waco.
*Crosthwait, R. Wilson, Waco.
*Crosthwait, W. L., Waco.
*Dudgeon, H. R., Sr., Waco.
*Dudgeon, Howard R., Jr., Waco.
*Garrett, Jas. M., Waco.
Gidney, Wm. H., West.
Goodman, Aubrey L., Waco.
Hale, Jas. W. (Hon.), Waco.
Hanks, Robt. J., Waco.
Harrington, Jno. T., Waco.
Harrison, D. A., Jr., Waco.
Hawkins, W. W., Waco.
*Hipps, Herbert E., Waco.
*Hoehn, F. Wm., Waco.
Howard, Stanley P., Waco.
Hubbs, Roy S., Palo Alto, Calif.
Husbands, Tom L., Waco.
Jaworski, H., Waco.
Jenkins, I. Warner, Waco.
*Johnson, Ernest A., Waco.
Kee, Jno. L., Waco.
*Klatt, Wesley W., Waco.
*Lattimore, Jno. E., Waco.
Magid, Moreton A., Waco.
*Manske, A. O. (Sec'y), Waco.
*McCauley, E. R., Moody.
Mewshaw, R. E. L., Waco.
Milam, E. A., Waco.
Miller, Claire F., Waco.
Miller, C. R. Coatswell, Pa.
Montgomery, Hazel I., West.
Mortland, S. Richard, Waco.
Murphy, Paul C., Waco.
Naylor, L. F., Waco.
Oliver, Tom M., Waco.
*Powell, Eugene V., Waco.
*Power, Paul H., Waco.
Reese, C. H., Waco.
*Roche, B. F., Waco.
Rottner, Mark H., Waco.
*Sadler, Leslie R., Waco.
Scanio, Thos. J., West.
Sewall, Lee G., Lyons, New Jersey.
Shipp, Ross, Waco.
Shipp, W. R. F., Lorena.
Simpson, Neill O., Waco.
Smith, C. C., Oklahoma City, Okla.
Smith, Edward, Waco.
*Souther, Wm. L., Waco.
Spencer, Shelby C., Waco.
Stainslav, Frank J., Waco.
Tabb, T. E., Waco.
Talley, J. E., Waco.
Thompson, Jno. R., McGregor.
Traylor, Clayton J., Waco.
Trice, Wm. G., Waco.

Trippet, Horace H., Waco.
Tyler, Russell E., Waco.
Warren, D. D., Waco.
Wells, W. Howard, Waco.
Witte, Wallace S., Waco.
Wood, W. A. (Hon.), Waco.
Wood, R., Spencer, Waco.
Woolsey, Fleta G., Waco.
Woolsey, Henry U., Waco.
*Woolsey, W. Jinkens, Waco.

MILAM COUNTY MEDICAL SOCIETY

Barkley, Thos. S., Rockdale.
Coulter, Hiram T., Rockdale.
*Crump, Thos. E. (Sec'y), Cameron.
Denson, Thos. L., Cameron.
Epperson, Albert S. (Hon.), Houston.
Fontaine, Wm. J., Cameron, Rt. 2.
Hubert, Jone S. (Pres.), Cameron.
Johnson, Cullen D., Thorndale.
Newton, Wm. R., Jr., Cameron.
Reed, Roy G. (Mil.), Cameron.
Richards, Jno. T., Rockdale.
*Rischar, Eduard, Cameron.
Shapiro, David, Cameron.
Somer, Frank A., Cameron.
Swift, Clifford G., Cameron.
Sessions, Isaac P. (Hon.), Rockdale.

NAVARRO COUNTY MEDICAL SOCIETY

Bowmer, Otho C., Corsicana.
Burnett, Samuel H., Corsicana.
Carter, Will W., Corsicana.
*David, J. Wilson, Corsicana.
Hamill, Dan B. (Pres.), Corsicana.
Kelton, Leslie E., Corsicana.
Logsdon, Wm. K., Corsicana.
*Miller, Dubart, Corsicana.
Miller, Will M. Corsicana.
Newton, Earl H., Corsicana.
Rosenbloom, Joseph, Trinidad.
Sanders, Gurley H., Kerens.
Shell, Wm. T., Jr., Corsicana.
*Shell, Wm. T., Sr., Corsicana.
Sneed, Wm. R. (Sec'y), Corsicana.
Wills, Thomas O., Corsicana.

THIRTEENTH OR NORTHEASTERN DISTRICT

Dr. R. G. Baker, Fort Worth, Councilor.

BAYLOR-KNOX-HASKELL COUNTIES MEDICAL SOCIETY

Balch, Edwin H., Seymour.
Barber, Lyman A., Seymour.
Bunkley, Eutus P., Stamford.
Bunkley, Jno. F. (Hon.), Seymour.
*Bunkley, Thos. A., Stamford.
Cadenhead, Jas. F., Weinert.
*Edwards, Thos. S., Knox City.
Eiland, David C., Munday.
Foy, Jas. W., Seymour.
Frizzell, Thos. P., Knox City.
Heard, Eli F., Goree.
Hudson, Isaac F., Stamford.
Johnson, Chas. E., Seymour.
Kimbrough, Ernest M., Haskell.
Lowry, Robert K. (Pres.), Seymour.
Newsem, Robt. L. (Sec'y), Munday.
Phillips, Gordon C., Haskell.
Rogers, Madison W., Rule.
Scott, Frank C., Haskell.
Smith, Arthur A., Munday.
Taylor, Lafayette F., Haskell.
Taylor, Wm. M., Goree.
Williams, Temple W., Haskell.
Wilson, J. Alton, Knox City.

CLAY-MONTAGUE-WISE COUNTIES MEDICAL SOCIETY

Carmen, E. M., Vashti.
Crumpler, Prentice, Jr., Bowie.
*Darwin, J. T. (Sec'y), Decatur.
Davis, W. W., Nocona.
Dean, Wesley N., Boyd.
Donnelly, Verner J., Bowie.
Greer, Albert, Henrietta.
Harris, Ewing P., Bowie.
Inabnett, W. T. (Pres.), Decatur.
Lawson, Jno. T., Bowie.
Neely, John W., Presidio.
Patton, F. M., Henrietta.
Riley, David C., Alvord.
Rogers, T. G., Decatur.
Russell, W. L., Rhome.
Shoultz, Vardeman H., Bridgeport.
Watsen, O. M., Jr., Bridgeport.
*Wright, Elbert W., Bowie.
Valcik, John H., Decatur.

EASTLAND-CALLAHAN COUNTIES MEDICAL SOCIETY

Ball, D., Cisco.
Blackwell, Ed. C., Gorman.
Blackwell, Geo. T., Gorman.
Brazda, Adolph W. (Pres.), Ranger.
Brown, Audie A., Gorman.
Brown, Lovell C., Eastland.
Carter, Chas. H., Eastland.
Caton, James H., Eastland.
Clark, Floyd E., Cisco.
Dill, John R., Rising Star.
Graham, E. L., Cisco.
Isbell, F. T., Eastland.
Jackson, Thos. G., Carbon.
Jackson, Walter L. (Dead), Ranger.
Jackson, C. L., Ranger.
Kuykendall, P. M., Ranger.
Powell, Eli, Cross Plains.
Rogers, David V., Gorman.
Stubblefield, M. L. (Sec'y), Baird.
Stubblefield, R. L. (In.), St. Louis, Mo.
Wier, A. K., Ranger.
Watkins, Wirter P., Eastland.

PALO PINTO-PARKER COUNTIES MEDICAL SOCIETY

Evans, Andrew J., Mineral Wells.
Lasater, Waldo B. (Pres.), Mineral Wells.
McCall, Jas. Don, Mineral Wells.
McCloud, Ben L. (Mil.), Graford.
*McCracken, J. H. (Hon.), Mineral Wells.
Patterson, A. M., Mineral Wells.
Pedigo, Paul C., Strawn.
Pedigo, Wm. S., Strawn.
*Roan, Leo N., Weatherford.
Roberson, Jno. F., Gordon.
Russell, Earl M., Weatherford.
Rohrer, Wm. M., Springtown.
Simmons, Phil R., Weatherford .
Smith, Jno. E., Weatherford.
Smith, Robt. H., Palo Pinto.
Spratt, Jno. T., Mingus.
Williams, Chas. B., Mineral Wells.
Williams, Chas. R., Mineral Wells.
Wright, Jas. B., Weatherford.
Yeager, Edward F. (Sec'y), Mineral Wells.

STEPHENS-SCHACKELFORD-THROCKMORTON COUNTIES MEDICAL SOCIETY

Berry, W. L., Throckmorton.
*Cartwright, H. H., Breckenridge.
Forrester, R. E., Moran.
Guinn, W. B., Breckenridge.
Harrell, J. E., Throckmorton.
Kessler, Calvin M., Odessa.
Murrie, R. G., Albany.
Parks, W. S., Breckenridge.
Parks, Walter S., Jr., Breckenridge.
Payne, Frank C. (Pres.), Breckenridge.
Webb, W. T., Breckenridge.
Wood, G. C., Breckenridge.
Younglood, D. J. R. (Sec'y), Breckenridge.

TARRANT COUNTY MEDICAL SOCIETY

Allen, Daisey E., Fort Worth.
Allison, J. A., Grapevine.
Allison, Wilmer L., Fort Worth.
Anderson, J. V., Fort Worth.
Anderson, R. B., Fort Worth.
*Andujar, John J., Fort Worth.
Anthony, E. E., Fort Worth.
Anthony, F. H., Fort Worth.
*Antweil, A., Fort Worth.
*Armstrong, W. F., Fort Worth.
Aurin, Fred B. (In.), Fort Worth.
Austin, Carl M., Fort Worth.
Axtell, E. C., Fort Worth.
Bain, Geo. P. (In.), Plainview.
Bailey, Noel R., Fort Worth.
*Baker, R. G., Fort Worth.
Ball, B. C., Fort Worth.
*Ball, Chas. E., Fort Worth.
*Barcus, J. R., Fort Worth.
*Barcus, W. S., Fort Worth.
Barker, Robert C., Fort Worth.
*Barrett, I. P., Fort Worth.
Barrier, Chas. W., Fort Worth.
Barrow, Wm. B., Fort Worth.
Beall, Frank C., Fort Worth.
Beall, K. H., Fort Worth.
Beaton, Hugh, Fort Worth.
Beavers, G. H., Jr., Fort Worth.
Bennett, Jerrell, Fort Worth.
Black, Thos. W., Fort Worth.
*Bobo, Zack, Jr., Arlington.
*Bond, Tom B., Fort Worth.
Bonelli, V. E., Fort Worth.
Bowden, Andy J. (Mil.), Fort Worth.
Brasher, R. V., Fort Worth.
*Brewster, C. Burke, Fort Worth.
Brown, Arthur, Fort Worth.
Brown, J. Hyal, Fort Worth.
*Brown, W. Porter, Fort Worth.
Burgess, R. M., Fort Worth.
Bursey, E. H., Fort Worth.
*Campbell, J. Franklin, Fort Worth.
Carpenter, N. C., Fort Worth.
Cassidy, John M. (Mil.), Fort Worth.
Chambers, James O., Fort Worth.
Childs, Tilden L., Jr., Fort Worth.
Chilton, W. E., Fort Worth.
Chorn, E. H., Fort Worth.
Church, John M. (Mil.), Fort Worth.
Claunch, DeWitt, Fort Worth.
*Clayton, Chas. F., Fort Worth.
*Cochran, J. R., Fort Worth.
Coffey, Alden, Fort Worth.
Cohen, Frank C., Fort Worth.
Cohn, Maurice H., Fort Worth.
Collins, J. D., Arlington.
Cook, W. G. (Hon.), Fort Worth.
Conner, Cooper M., Fort Worth.
Covert, J. D., Fort Worth.
Crabb, M. H., Fort Worth.
Crawford, Wm. M., Fort Worth.
Cross, T. J., Fort Worth.
Cyrus, E. M., Jr., (In.), Galveston.
Cummins, J. B., Fort Worth.
Daly, Jack, Fort Worth.
Davis, James H. (Mil.), Fort Worth.
*Day, Giles W., Fort Worth.
Deaton, Hobart O., Fort Worth.
Ditto, H. Howard, Fort Worth.
Doss, A. K., Fort Worth.
Douglass, Hal C., Fort Worth.
Dunn, Nelson L., Fort Worth.
Duringer, W. C., Fort Worth.
Emery, O. J., Fort Worth.
*Enloe, Geo. R., Fort Worth.
Eschenbrenner, J. W., Fort Worth.
Fershtand, J. B., Fort Worth.
*Foster, W. C., Handley.
Francis, F. W., Fort Worth.
Funk, Theron H., Fort Worth.
Furman, Jack M., Fort Worth.
*Garnett, J. W., Jr., Fort Worth.
Garrett, C. C., Fort Worth.
Givens, J. M., Fort Worth.
*Godley, L. O., Fort Worth.
Goldberg, A. I., Fort Worth.
Goldberg, Morton N., Fort Worth.
*Goodman, T. L., Fort Worth.
Gough, R. H., Fort Worth.
Grammer, J. H., Fort Worth.
Grammer, R. B., Fort Worth.
Greines, Abe, Fort Worth.
Greve, Anna M., Fort Worth.
Grice, Thos. W., Fort Worth.
Griffith, M. A., Fort Worth.
*Grogan, O. R., Fort Worth.
*Grogan, R. L., Fort Worth.
Guerra, R. Lopez, Fort Worth.
Haffke, Oscar W., Fort Worth.
Hall, E. P., Fort Worth.
Hall, E. P., Jr., Fort Worth.
Hallmark, J. A., Fort Worth.
*Halpin, Frank W., Fort Worth.
Hammack, John A., Kennedale.
Hancock, E. C., Arlington.
Harper, H. W., Jr., Fort Worth.
Harris, Chas. H., Fort Worth.
Harris, Chas. H., II, (In.), Fort Worth.
Harris, Earl, Fort Worth.
Hawker, L. J., Fort Worth.
Hawkins, C. P., Fort Worth.
Hayes, C. F., Fort Worth.
Helbing, H. V., Fort Worth.
Hewatt, J. W., Fort Worth.
Hiett, Carey, Fort Worth.
Hightower, L. P., Fort Worth.
*Higgins, W. P., Jr. (Sec'y), Fort Worth.
Holt, C. Zeno (In.), Fort Worth.
*Hood, Grace H., Fort Worth.
Hook, James H., Fort Worth.
*Horn, Will S., Fort Worth.
Howard, E. L. (Pres.), Fort Worth.
Howard, Rex J. (In.), Dallas.
Howard, Rex Z., Fort Worth.
Howell, Wm. L. (Mil.), Fort Worth.
Huffman, A. M., Fort Worth.
*Hulsey, Sim, Fort Worth.
*Hyde, X. R., Fort Worth.
*Isaacks, Hub E., Fort Worth.
*Jackson, A. E., Fort Worth.
Jackson, H. T., Fort Worth.
Jagoda, Samuel, Fort Worth.
*Jenkins, W. N., Fort Worth.
Jewell, Geo. W., Jr., Fort Worth.
Kelley, J. A. (Hon.), Fort Worth.
Key, W. F. (Hon.), Fort Worth.
Kibbie, Horace K., Fort Worth.
Kibbie, Kent V., Fort Worth.

King, Gerald A., Fort Worth.
Kingsbury, H. B., Fort Worth.
Kramer, J. T., Fort Worth.
Lace, W. T., Fort Worth.
Lackey, W. C. (Dead), Fort Worth.
Lacy, Geo. W., Fort Worth.
Ladd, A. D., Fort Worth.
Lange, A. A., Fort Worth.
Lauderdale, T. L., Fort Worth.
Lawson, J. Mack, Fort Worth.
Lees, C. R., Fort Worth.
Lenox, W. R., Fort Worth.
Leon, Wm. R., Fort Worth.
Levy, Louis J., Fort Worth.
*Littlepage, H. B., Fort Worth.
Lorimer, W. S., Fort Worth.
Lyle, Judge M., Fort Worth.
Major, A. D., Fort Worth.
Mallard, R. S., Fort Worth.
Marrs, W. D., Fort Worth.
Matheson, D. N., Fort Worth.
*McCarroll, M. C., Fort Worth.
McCollum, Chas. H., Jr., Fort Worth.
McDonald, Audrey J., Taylor.
McDonald, R. P., Fort Worth.
McKee, Frank, Fort Worth.
McKenzie, Walten H., Fort Worth.
McKissick, J. F., Arlington.
McKnight, W. B. (Hon.), Mansfield.
McKnight, Wm. Hodges, Fort Worth.
McLean, J. H., Fort Worth.
*McVeigh, J. F., Fort Worth.
*Mitchell, Gatlin, Fort Worth.
Moore, Kenneth G., Fort Worth.
Morris, A. J., Fort Worth.
Mulkey, Young J., Fort Worth.
*Murchison, S. J. R., Fort Worth.
Myers, T. B. (Mil.), Fort Worth.
Needham, R. H., Fort Worth.
Neighbors, DeWitt, Fort Worth.
*Nesbit, P. M., Arlington .
*Nies, W. B., Fort Worth.
, Nifong Harry D., Mansfield.
*O'Bannon, R. P., Fort Worth.
O'Reilly, John J. (Mil.), Fort Worth.
Oswalt, Chas. E., Jr., Fort Worth.
Ott, W. O., Fort Worth.
*Owen, May, Fort Worth.
*Parsons, W. F., Fort Worth.
Petta, Walter B., Fort Worth.
Phillips, O. M., Fort Worth.
*Phillips, W. G., Fort Worth.
Ponton, A. R., Jr. (Mil.), San Antonio.
Potts, John, Fort Worth.
Price, Sidney A., Fort Worth.
Pumphrey, A. B., Fort Worth.
Radtke, H. P., Fort Worth.
*Rathgeber, Van D., Fort Worth.
Readinger, Ivan H., Fort Worth.
Reeves, E. E., Fort Worth.
*Reeves, L. H., Fort Worth.
Renshaw, Horace S., Fort Worth.
Richardson, J. J., Fort Worth.
Riley, Jack C. (In.), Fort Worth.
Roberts, A. D. (Mil.), Fort Worth.
Roberts, A. L., Fort Worth.
Roberts, Lily, Fort Worth.
Rogers, Ernest D., Fort Worth.
Rogers, R. Cromwell, Fort Worth.
Rumph, D. M., Fort Worth.
Rumph, Mal, Fort Worth.
Rumph, T. G., Fort Worth.
*Sanders, Frank G., Fort Worth.
Saunders, R. F., Fort Worth.
Schenck, C. P., Fort Worth.
Schoolfield, E. C., Fort Worth.
*Schoonover, Frank S., Fort Worth.
Scroggie, Val D., Fort Worth.
*Schwarz, Edwin G., Fort Worth.
*Sealy, W. Burgess, Fort Worth.
Sewell, Robt. L., Fort Worth.
Shaw, E. L., Fort Worth.
Sheddan, Frank G., Fort Worth.
Shelley, Harold J., Fort Worth.
Shilling, Harold C., Fort Worth.
Shoemaker, J. W., Fort Worth.
Siddons, Geo. Y., Fort Worth.
Simon, John (Mil.), Fort Worth.
Smith, Wallace B., Fort Worth.
*Snyder, F. L., Fort Worth.
Spencer, Robt. S. (Mil.), Fort Worth.
Stanford, Henry (In.), Fort Worth.
Steger, J. H., Fort Worth.
Stow, R. C., Jr., Fort Worth.
Stout, S. E., Fort Worth.
Sumner, Wendell W., Fort Worth.
*Swift, W. B., Fort Worth.
Tadlock, M. E., Fort Worth.
Tatum, W. C., Fort Worth.
Taylor, Eliz. A., Fort Worth.
*Taylor, Holman, Fort Worth.
Taylor, Holman, Jr. (In.), Ann Arbor, Mich.
Teague, Wm. H., Fort Worth.
*Terrell, Blanche O., Fort Worth.
*Terrell, C. O., Fort Worth.
Terrell, C. O., Jr. (Mil.), Fort Worth.
*Terrell, T. C., Fort Worth.
Thomas, H. C., Fort Worth.
Thomas, Harry P., Fort Worth.
Thomas, R. M., Mansfield.
Thomason, T. H., Fort Worth.
Thompson, W. R. (Em.), Fort Worth.
Tom, J. C., Jr., Fort Worth.
Tottenham, J. W., Fort Worth.
*Tottenham, J. W., Jr., Fort Worth.
Touzel, C. S. E., Fort Worth.
Trigg, Henry B., Fort Worth.
*Trigg, Ross, Fort Worth.
Tucker, J. T., Fort Worth.
Van Zandt, I. L., Fort Worth.
Walker, Webb, Fort Worth.
*Waltrip, P. M., Jr., Fort Worth.
Webb, Wm. S., Fort Worth.
*West, W. B., Fort Worth.
*White, R. J., Fort Worth.
Wier, E. M., Fort Worth.
*Wiggins, John A., Jr., Fort Worth.
Williams, Harold M., Fort Worth.
Wilson, Stephen W., Fort Worth.
Wyss, Herbert E., Keller.
*Wise, Joe R., Fort Worth.
*Woodward, C. S., Arlington.
Woodward, M. Lee (Hon.), Deming, N. M.
*Woodward, Valin R., Arlington.
Wright, J. Walker, Fort Worth.

TAYLOR-JONES COUNTIES MEDICAL SOCIETY

Adams, Clinton E., Abilene.
*Adamson, W. B., Abilene.
Alexander, Jas. M., Abilene.
Bailey, S. W., Abilene.
Bare, Norton H., Abilene.
Beckman, M. A., Dallas.
Boehning, Harold H., Abilene.
Boyd, Virginia H., Abilene.
Bridges, Jas. P., Abilene.
Burditt, J. N., Abilene.
Campbell, M. E. (Hon.), Abilene.
Cash, W. Auda V., Abilene.
Cockerell, Earl R. (Mil.), Abilene.
Crow, Jack A (Sec'y)., Abilene.
Duff, J. C., Anson.
Estes, J. M., Abilene.
Estes, Sol B., Abilene.
*Gardner, Chester B., Merkel.
Gibson, Jno. P. (Mil.), Abilene.
Grubbs, L. F., Abilene.
Hedrick, T. Wade, Abilene.
Hodges, Frank C., Abilene.
Hollis, L. W., Jr., Abilene.
Hollis, Scott W., Abilene.
*Hudson, Frederick E., Stamford.
Johnson, L. F., Abilene.
Kirkpatrick, R. B., Abilene.
Leggett, Claude B. (Hon.), Abilene.
Little, O. W., Abilene.
*Magee, J. D., Jr., Abilene.
McCreight, Wm. J., Anson.
McDonald, Donald H. (Mil.), Stamford.
McFadden, C. A., Abilene.
McNeil, Melba, Abilene.
Metz, Louis F., Stamford.
Middleton, E. E. (Mil.), Abilene.
Patillo, Guy L., Abilene.
Pickard, L. J., Abilene.
Pope, A. J., Abilene.
Porter, Bruce M., Abilene.
*Prichard, C. L., Abilene.
Pryor, Dr. Geo. E., Jr., Stamford.
*Ramsey, Wayne V., Abilene.
Rhodes, Ben F., Abilene.
Saddler, Wm. T. (Pres.), Merkel.
Sellers, Erle D., Abilene.
*Snow, Wm. R., Abilene.
Southard, Dallas, Stamford.
Taylor, Floyd D., Abilene.
Thurman, Geo. D., Abilene.
Tull, Raymond H., Abilene.
*Varner, R. W., Abilene.
Webster, L. J., Abilene.
Weir, Wm. C., Hamlin.
Williams, Chas. F., Abilene.
Williams, W. H. (Mil.), Abilene.
Williamson, Lee, Abilene.

WICHITA COUNTY MEDICAL SOCIETY

Adams, Walter B., Sr., Wichita Falls.
Adams, Walter B., Jr., Wichita Falls.
Allen, Charles C., Wichita Falls.
Arrington, Jno. H., Wichita Falls.
Atkinson, Curtis, Wichita Falls.
Bailey, Edward B., Wichita Falls.
Bishop, Wm. A. (Mil.), Wichita Falls.
Brown, Chas. H. (Mil.), Wichita Falls.
Carpenter, Phillip A., Burkburnett.
Caskey, Marion W., Wichita Falls.
Clark, Gordon G., Iowa Park.
Collard, Felix R., Wichita Falls.
Collins, Bailey R., Wichita Falls.
Collins, Robt. P., Wichita Falls.
Cox, Emelious A., Wichita Falls.
Cramer, Samuel E. (Hon.), Electra.
*Crump, Wm. E., Wichita Falls.
Daily, Robt. L. (Sec'y), Wichita Falls.
Dorbandt, Barton W., Wichita Falls.
Egdorf, Otto C., Wichita Falls.
Fish, Pascal E., Electra.
Frey, Conrad, Wichita Falls.
Glover, Leonard A., Wichita Falls.
Glover, Milton H., Wichita Falls.
Guest, Jas. C. A., Wichita Falls.
Hall, Joseph D., Wichita Falls.
Hargrave, Robt. L., Jr. (Mil.), Wichita Falls.
Harper, Jno. W., Jr., Wichita Falls.
Harrison, Wm. G., Jr., Wichita Falls.
Hartsook, Chas. R., Wichita Falls.
Heymann, Julius A., Wichita Falls.
Holland, Lewis B., Wichita Falls.
Jacobi, Rudolph E., Wichita Falls.
Johnson, Jas. A., Wichita Falls.
*Kanatser, Joseph E., Wichita Falls.
Kiel, Oliver B., Wichita Falls.
Kimbrough, Orman T., Wichita Falls.
King, Thos. C., San Antonio.
Knox, Roland F., Wichita Falls.
Landon, Fred R., Wichita Falls.
Leach, Austin F., Wichita Falls.
Ledbetter, Wm. Harry, Wichita Falls.
*Ledford, Harry P. (Pres.), Wichita Falls.
*Lee, Quincy B., Wichita Falls.
*Lee, Jas. T., Wichita Falls.
Little, Jas. A., Wichita Falls.
Little, Raymond D. (Mil.), Wichita Falls.
Lovett, Jas. Poe, Olney.
Lowry, Wm. P., Wichita Falls.
Lynch, Thos. C., Wichita Falls.
Manar, Roger W., Wichita Falls.
*Mangum, Carl E., Wichita Falls.
Mast, Jno. R., Wichita Falls.
McConchie, Richard D., Wichita Falls.
McFatridge, Keith W., Wichita Falls.
*Meredith, Duane, Wichita Falls.
*Meredith, Elisha F., Olney.
*Monroe, Charles W., Electra.
*Nail, Jas. B., Wichita Falls.
Nelson, Richard L., Wichita Falls.
Ogden, Wm. H., Electra.
Parker, Wm. L., Wichita Falls.
*Parmley, Tim H., Electra.
Parmley, Van S., Electra.
Parnell, Luther D., Wichita Falls.
Pattilo, Albert D., Jr., Wichita Falls.
Peters, James I., Wichita Falls.
Pierce, A. W. (Mil.), Wichita Falls.
Powers, Wm. L., Wichita Falls.
Prichard, Horace D., Wichita Falls.
Reagan, Jno. R., Wichita Falls.
Reser, Wayne A., Wichita Falls.
*Robertson, David L. (Mil.), Wichita Falls.
Rosenblatt, Wm. (Mil.), Wichita Falls.
Rundell, Wm. K., Wichita Falls.
Russell, Isaac D., Burkburnett.
Seay, Jos. A., Wichita Falls.
Seibold, Geo. J. (Mil.), Wichita Falls.
Simmons, L. Nolen, Wichita Falls.
Smith, M. Zenos, Wichita Falls.
*Smith, Percy K., Wichita Falls.
Stripling, Louis F., Wichita Falls.
Sullivan, Harley C., Burkburnett.
*Whiting, Walter B., Wichita Falls.
Wilcox, Clark A. (Dead), Wichita Falls.
Wilson, Oscar W., Wichita Falls.

WILBARGER COUNTY MEDICAL SOCIETY

Borchardt, Alvin Lee (Pres.), Vernon.
Coleman, Wm. C., Vernon.
Hollar, Emory D., Vernon.
Lemee, Raymond A. (Sec'y), Vernon.
Miller, Bradford W., Vernon.
Moore, Wm. R., Vernon.
Muirhead, James J., Vernon.
Restivo, Jack L., Vernon.
Rogers, Albert C., Vernon.
Shipman, Joe, Vernon.
Shipman, Virginia, New Orleans.
Slaugenhop, J. J., Vernon.

YOUNG-JACK-ARCHER COUNTIES MEDICAL SOCIETY

Conner, Paul K., Jacksboro.
Devine, Blaine, Graham.
Edwards, B. F. (Mil.), Graham.
Filmore, R. S. (Mil.), Jacksboro.
Gowan, R. E. L. (Sec'y), Graham.
Griffin, B. B., Graham.
*Griffin, H. E., Graham.

Harrell, Fred S., Olney.
Lovett, R. E. (Mil.), Olney.
*McClure, C. C., Jacksboro.
McKinney, H. C., Olney.
Oates, K. D., Graham.
Padgett, Harrell O. (Mil.), Graham.
*Padgett, W. O., Graham.
Rosser, Virgil O., Jr., Graham.
Winstead, D. Edgar (Pres.), Graham.
Woods, David R., Olney.

FOURTEENTH OR NORTHERN DISTRICT

Dr. C. C. Nash, Dallas, Councilor.

COLLIN COUNTY MEDICAL SOCIETY

Bush, W. Holloway, McKinney.
Collins, J. S., Celina.
Corry, A. C., Farmersville.
Erwin, J. C., Jr., McKinney.
Miller, J. E., McKinney.
Mitchell, Oliver T., Plano.
Morrow, R. E., McKinney, Rt. 2.
Saye, W. L., Frisco.
Shumway, Chas. M., McKinney.
Walker, Robt. N., Celina.
Wolford, H. F. (Pres.), McKinney.
Wright, Will C., Farmersville.
Wysong, C. E., McKinney.
Wysong, H. Dudley, McKinney.
Wysong, W. Scott, Jr. (Sec'y), McKinney.
Wysong, W. Scott, Sr., McKinney.

COOKE COUNTY MEDICAL SOCIETY

*Atchison, Jas. W. (Sec'y), Gainesville.
Hawk, Hiram P. (Pres.), Gainesville.
Mills, Charles K., Gainesville.
*Myrick, Thos. S., Muenster.
Thayer, Claude B., Gainesville.
*Thomas, Ira L., Gainesville.
*Whidden, Rufus C., Gainesville.
*Yarborough, Silas M., Gainesville.

DALLAS COUNTY MEDICAL SOCIETY

Abramson, Jno. H. (Mil.), Dallas.
Adams, Geo. (Mil.), Dallas.
Addison, R. P., Dallas.
*Alexander, Jo C., Dallas.
Alexander, Lee J., Dallas.
Alexander, Samuel A., Dallas.
Alfieri, Anthony L., Dallas.
Allday, Louie E., Dallas.
Allen, Burton W., Dallas.
*Allison, Wilfred J., Dallas.
Altick, Frank J., Dallas.
Altman, Wm. A., Dallas.
Anderson, L. R., Dallas.
Andres, Reubin (Mil.), Dallas.
Andrews, B. C., Dallas.
Andrews, Warren, Dallas.
Archer, Maurice C. (In.), Dallas.
Armbrust, Chas. A. Jr. (In.), Dallas.
Arnold, Geo. K. (Mil.), Dallas.
Arnold, Lawrence E., Dallas.
Aronoff, B. L., Dallas.
Aronson, H. S., Dallas.
Ashby, Jno. E. Dallas.
*Ashworth, Chas. T., Dallas.
Aten, Eugene L., Dallas.
Atkinson, Geo. N., Jr. (Mil.), Dallas.
Ault, C. A., Dallas.
Austin, Dale J., Dallas.
Austin, Florence W., Dallas.
Austin, Frank H., Dallas.
Austin, Ona Mae R., Dallas.
Baden, Wayne F. (In.), Dallas.
Bagwell, Jno. S., Dallas.
Baird, Sidney S., Dallas.
Baird, Wm. Leroy, Dallas.
Baker, Bryant O., Dallas.
Baker, Jno. O., Dallas.
*Baldwin, Alvin, Jr., Dallas.
Barnes, Dorsey K., Dallas.
Barnett, Wm. E., Dallas .
Barr, Wm. T., Dallas.
Barta, C. K. (Mil.), Dallas.
*Barton, Robt. M., Dallas.
Basom, Wm. C., Dallas.
*Bass, Jas. W., Dallas.
Baxter, Jas. H., Dallas.
*Beall, Jno. R., Dallas.
Beaver, N. B., Dalla.
Beckering, Henry H., Dallas.
Beddoe, Robt. E. (Hon.), Galveston.
Beddow, L. D. (Mil.), Dallas.
*Bell, Marvin D., Dallas.
Bennett, Thos. R., Jr. (In.), Dallas.
Berger, B. J., Dallas.
Berk, Ira J., Dallas.
Berk, Wm. R., Dallas.
Black, Chas. I. (In.), Dallas.
Black, J. H., Dallas.
*Bland, Leonard F., Dallas.
Blend, Max H. (In.), Dallas.
*Block, Harold M., Dallas.
Blocker, Wm. P., Jr. (Mil.), Dallas.
Bonner, Dickson P. (In.), Dallas.
Boone, M. A., Dallas.
Bounds, Murphy, Dallas.
Bourland, Jno. B., Dallas.
Bourland, J. W., Dallas.
Bourland, J. W., Jr., Dallas.
*Bowyer, Mack F. (In.), Dallas.
Boyer, L. A., Dallas.
Bradfield, Jno. L., Dallas.
*Bradford, Wm. H., Dallas.
Bralley, Ernest M., Jr. (Mil.), Dallas.
Branch, Wm. M. (Mil.), Dallas.
Brandau, Wm. W. (Hon.), Dallas.
Brandt, Otto, Jr. (Mil.), Dallas.
Brannin, Dan, Dallas.
Brannin, E. B., Dallas.
*Brau, John G., Dallas.
*Breihan, E. W., Dallas.
*Brereton, G. E., Dallas.
Brooks, Ernest J., Dallas.
Brooksaler, Fred S., Dallas.
Brown, C. Frank, Dallas.
Brown, Geo. W. (In.), Dallas.
Brown, Olen E., Dallas.
Brown, S. Roland (Mil.), Dallas.
Brown, Wm. W., Jr. (In.), Dallas.
Browne, Wm. C., Dallas.
Bruton, Emmett B., Dallas.
Bryan, Eugene K. (Mil.), Dallas.
Bryant, David W. (Mil.), Dallas.
*Buchanan, J. Forest, Dallas.
Buckner, Kathryn, Philadelphia.
Buehler, Martin S., Dallas.
Buford, Ben R., Dallas.
Burford, Raymond W., Dallas.
Bumpass, Stewart R., Dallas.
Burgess, Geo. A. (Mil.), Dallas.
Burnside, Ronald M., Dallas .
Bush, W. H. (Mil.), Dallas.
Bussey, C. D., Dallas.
*Butte, Felix L., Dallas.
Byrom, Emmett T., Dallas.
Bywaters, T. W., Dallas.
Caillet, O. Rene, Dallas.
Cairns, A. B., Dallas.
Caldwell, Geo. T., Dallas.
Caldwell, Janet A., Chicago.
Calhoun, Nina Fay, Dallas.
Calhoun, Thos. J., Dallas.
Cameron, Lawrence C., Dallas.
Cantrell, Roy H., Dallas.
Carlisle, Chas. P., Dallas.
Carlisle, Geo. L., Dallas.
*Carlson, Glenn D., Dallas.
*Carman, H. Frank, Dallas.
*Carpenter, Robt. G., Dallas.
Carrell, Brandon, Dallas.
Carroll, Benj. H., Dallas.
Carswell, Winston E., Dallas.
Carter, C. B., Dallas.
Carter, Chas. F., Dallas.
Carter, David W., Jr., Dallas.
Carter, Earl L., Dallas.
*Cary, Edward H., Dallas.
Chaney, Clyde E., Dallas.
Chapman, Jno. S., Dallas.
Cheek, Jimmie H. (In.), Dallas.
Childress, Wm. Ben (In.), Stamford.
Cinnamon, Alfred M., Dallas.
*Clark, Harold G., Dallas.
*Cochran, H. Walton, Dallas.
*Coggeshall, Howard C., Dallas.
Collier, Gates (Mil.), Dallas.
Cook, Thos. E., Dallas.
Cookerly, Van (Mil.), Dallas.
Cooper, Jack C., Dallas.
Copeland, F. R., Dallas.
Copeland, H. V., Grand Prairie.
Cowart, Robt. W., Dallas.
Cox, Eli R., Dallas.
*Cox, Kelly, Dallas.
Crow, W. E., Dallas.
*Crutcher, Howard K., Dallas.
Cupp, Charles D., Grand Prairie.
Daniel, Ruby K., Dallas.
*Darrough, L. E., Dallas.
Dathe, Richard A., Dallas.
Davidson, G. A., Dallas.
Davis, David B., Dallas.
Davis, J. Spencer, Dallas.
Davis, Leo G., Dallas.
Davis, Milton V. (Mil.), Dallas.
Dawson, J. L., Dallas.
Deatherage, W. R. (Mil.), Dallas.
Decherd, H. B. (Hon.), Dallas.
DeHaro, J. Anthony (Mil.), Dallas.
DeLange, Arnott, Dallas.
Denton, Guy T., Sr., Dallas.
Denton, Guy T., Jr., Dallas.
D'Errico, Albert P., Dallas.
*Devereux, W. P., Dallas.
Diddle, Albert W., Dallas.
Donald, Homer, Dallas.
Donnelly, Allen D., Grand Prairie.
Donoho, Chas. P., Dallas.
Doolittle, H. M., Dallas.
Dorman, J. H., Dallas.
Dowis, J. M., Dallas.
Downs, Jas. T., Jr., Dallas.
Dozier, Fred S., Dallas.
Driver, John B., Dallas.
*Driver, Sim, Dallas.
Dryden, Chas. B., Jr. (In.), Dallas.
*Duckett, J. W., Dallas.
Duncan, Chas. N. Dallas.
*Duncan, Horace E., Dallas.
*Dunlap, Elbert, Dallas.
*Dunlap, J. Hudson, Dallas.
*Dunlap, Jno. E., Dallas.
*DuPuy, Howard B., Dallas.
Edwards, Wm. L., Dallas.
Embree, Jno. W., Dallas.
Estes, Ivan A., Dallas.
Evans, Allan C. (In.), Dallas.
Evans, E. L. (Mil.), Dallas.
*Evans, W. G., Dallas.
Everhart, Merrill W., Dallas.
*Fashena, Gladys J., Dallas.
Ferguson, Doyle W., Dallas.
Fetzer, Lewis W., Dallas.
Fiegel, Walter L., Carrollton.
Finnegan, Chas. R., Dallas.
Folsom, A. I., Dallas.
Fowler, W. W. (Sec'y), Dallas.
Fox, Everett C. (Pres.), Dallas.
*Franklin, Floyd S., Dallas.
Franklow, C. D., Dallas.
Freed, Harold, Dallas.
Freedman, S. M., Dallas.
Frew, Athol L., Jr. (In.), Dallas.
Fry, Elma May, Dallas.
Fry, Murcock D., Dallas.
Fuller, Wm. W., Dallas.
Fuqua, Carl F. (Mil.), Dallas.
Fuqua, W. N., Jr., Dallas.
Galt, Sidney, Dallas.
Garrett, H. Grady, Dallas.
Gary, Chas. L., Jr. (In.), Dallas.
Gendel, Joseph, Dallas.
George, Ella Mary, Dallas.
Gessner, F. E., Dallas.
Gibbins, Olin W., Dallas.
Gilbert, Allen C. (Mil.), Dallas.
*Gilbert, Taylor C., Dallas.
Giles, Robt. B., Dallas.
Gill, Atticus J., Dallas.
Gill, Horace E. (In.), Dallas.
Girard, Percy M., Dallas.
Goff, Gomer F., Dallas.
*Goforth, Jno. L., Dallas.
Goggans, Roy F., Dallas.
*Goode, Jno. V., Dallas.
Gordon, E. S., Dallas.
Gottlich, Arthur P., Dallas.
Grafton, Edwin G., Jr. (Mil.), Dallas.
Graham, Jas. F., Dallas.
Green, Falvey R., Dallas.
Green, Tim R., Dallas.
*Griffin, Ben H., Dallas.
Griffin, Otho P., Dallas.
*Grollman, Arthur, Dallas.
Guerriero, Wm. F., Dallas.
Haag, Edmund L., Jr. (Mil.), Dallas.
Hacker, Guy L., Dallas.
Hackney, U. P., Dallas.
Hale, Martha Helen, Dallas.
Haley, Wm. E., Dallas.
Halpern, Salmon R., Dallas.
Hampton, J. A., Dallas.
Harber, Harry P., Dallas.
Hardin, Hal W. (Mil.), Dallas.
Harkins, Jas. E., Mil.), Dallas.
Harper, Jack C., Dallas.
Harrel, Don G., Dallas.
Harrington, Francis T., Dallas.
*Harrington, S. F., Dallas.
*Harris, Alfred W., Dallas.
Harris, N. J., Dallas.
Harris, Worth W., Dallas.
Harrison, Ben F., Jr., Dallas.
Harrison, Gaston G., Dallas.
*Harrison, Tinsley R., Dallas.
Hart, G. A., Dallas.
Hartin, Richard B., Garland.
Hartman, Jas. M., Garland.
Harvill, T. Haynes (Mil.), Dallas.
Hawkins, Hubert F., Dallas.
Hawley, Geo. M. B. II (In.), Dallas.
Hawley, J. Leeper, Dallas.
Henderson, Chas. C. (In.), San Diego, Calif.
Hennen, J. C., Garland.
Henry, Albert C., Jr., Dallas.
Henry, D. J. (Mil.), Dallas.

Hernandez, Moises S., Grand Prairie.
Herndon, Jas. H., Dallas.
Herrmann, Cornelius L. (Mil.), Dallas.
Heyer, Howard E., Dallas.
Hill, S. M., Dallas.
*Hill, Jos. M., Dallas.
Hinds, Edward C. (In.), Dallas.
Hodges, J. Shirley, Dallas.
Hodges, Leon, Dallas.
Hoefer, Carl A., Dallas.
Hogan, Howard, Dallas.
Holman, Jas. (In.), Dallas.
Holmes, Robt. L., Jr. (In.), Dallas.
Holt, J. O. S., Jr., Dallas.
Hood, Marianna, Dallas.
*Hopkins, May Agnes, Dallas.
*Horn, Fred W., Grand Prairie.
Horn, J. Morris, Dallas.
House, Royce E., Garland.
Howard, Geo. W., Dallas.
Howard, W. E. (Hon.), Dallas.
Howell, Jas. B., Dallas.
Hudgins, B. E., Hutchins.
Hudson, W. Lee, Dallas.
Hurt, L. B., Dallas.
Hutchison, Elizabeth S., Dallas.
Irvine, Eugene J., Dallas.
Jablow, Harry B., Dallas.
Jackson, Reuben W., Dallas.
Jackson, Rice R. (Hon.), Dallas.
*Jackson, Mary Ruth, Dallas.
Jackson, Michael C., Dallas.
Jacobson, Harry B., Dallas.
Jamison, Cyrus W., Dallas.
Jansen, Harold G., Dallas.
Jayson, Arthur V. (Mil.), Dallas.
*Jenkins, Jno. L., Dallas.
Jenkins, Speight, Dallas.
Jones, Edwin L. (Hon.), Dallas.
*Jones, Geo. M., Dallas.
Jones, J. Guy, Dallas.
*Jones, W. D., Dallas.
Jones, Wm. E., Dallas.
Jordan, Carl A. (In.), Dallas.
Kahn, S. H., Dallas.
Kaplan, Harry L. (Mil.), Dallas.
Katz, S. M., Dallas.
Keene, Albert H., Richardson.
Keller, L. L., Dallas.
Kelley, Chas. W., Dallas.
*Kelly, Thos. E., Dallas.
Kemp, Hardy A. (Mil.), Dallas.
Kemper, Thos. W., St. Louis, Mo.
Kent, Jas. M., Dallas.
Kerr, Jack G., Dallas.
Kidd, Frank H., Jr.(Mil.), Dallas.
*Kilgore, Donald G., Dallas.
Kindley, Geo. C., Dallas.
King, Karl B., Dallas.
Kirkham, Judd H., Dallas.
Kirksey, Thos. M., Dallas.
Klinger, Paul E., Jr. (In.), Dallas.
Knickerbocker, B. A., Dallas.
Knight, Marvin P., Dallas.
Knowles, W. Mood, Dallas.
Knox, Robt. A., Dallas.
Koch, Wm. T., Jr. (In.), Dallas.
Kreymer, Geo. C., Dallas.
LaDue, Chas. N., Dallas.
Lancaster, Mary Agnes, Dallas.
Lanius, Jno. W., Dallas.
Langston, Wm. G. (Mil.), Dallas.
Launey, Geo. V., Dallas.
*Laugenour, Dudley, Dallas.
Lee, Jack B. (Mil.), Dallas.
*Lee, Ridings E., Dallas.
Leebron, Wm. M., Lake Dallas.
Leeper, Edward P., Dallas.
*Legg, Eugene P., Dallas.
Levin, Paul M., Dallas.
Levy, Harry R., Dallas.
Light, Flominda, Dallas.
Lindsay, G. A., Dallas.
Lipscomb, Joe L. (In.), Dallas.
Lively, Wm. M., Jr., Dallas.
LoBello, Leon C. (Mil.), Dallas.
Loftis, Earl L., Dallas.
Long, Gerald D., Dallas.
Long, Troy F., Dallas.
Loomis, Edgar W., Dallas.
Looney, W. W., Dallas.
*Love, Frances M., Dallas.
Love, Thos. S., Dallas.
Ludden, Keene F. (In.), Dallas.
Luecke, P. E., Dallas.
Lyon, Edward G., Dallas.
Maddox, W. Gordan, Dallas.
Maffett, Minnie L., Dallas.
Mahon, G. D., Dallas.
*Mantooth, Walter B. (In.), Dallas.
*Marchman, Oscar M., Dallas.
Marshall, Jas. H., Dallas.
*Martin, Chas. L., Dallas.
Martin, Jas. M. (Hon.), Dallas.
Martin, W. E., Dallas.
Martinak, Richard E. (In.), Dallas.
Mason, Porter K., Dallas.
*Massey, Warren E., Dallas.
Mathews, Paul W., Dallas.
Maupin, Wm. A. (Hon.), Rowlett.
Maxfield, Geo. S., Dallas.
Maxfield, J. R., Sr., Dallas.
*Maxfield, J. R., Jr., Dallas.
*Mazer, Morton L., Dallas.
McBride, Dayton C., Dallas.
McBride, R. B., Dallas.
McCallum, Chas., Mesquite.
McClung, Hugh L., Dallas.
*McCracken, J. H., Jr., Dallas.
*McCullough, Malcom K., Dallas.
McDonald, W. D., Dallas.
McFarland, Gordon B., Dallas.
McGee, Aubrey S., Dallas.
McGuire, Jos. H., Dallas.
*McIver, Julius, Dallas.
McLaurin, Hugh L., Dallas.
McLaurin, Jno. G., Dallas.
McLeod, Jas. N., Dallas.
McNatt, Malcom (Mil.), Dallas.
McNeill, Arch J., Dallas.
McPherson, V. L., Dallas.
Meisenbach, Albert E., Jr., Dallas.
Mendel, E. B., Dallas.
*Mendenhall, Elliott, Dallas.
Mengert, Wm. F., Dallas.
Meredith, Daniel T. (In.), Dallas.
Metz, M. Hill (Mil.), Dallas.
*Miller, Tate, Dallas.
Milliken, Sam E. (Hon.), Dallas.
Mills, James T., Dallas.
Mims, Arthur T. (In.), Dallas.
Minnett, Jno. S., Dallas.
Mitchell, Harry J., Dallas.
Montgomery, Henry G., Dallas.
Moody, Joe Vern, Dallas.
Mooney, Ken, Dallas.
Moore, S. Halcuit, Dallas.
*Moore, H. Leslie, Dallas.
*Moore, Ramsay H., Dallas.
*Moore, Robt. L., Dallas.
Morris, A. Truett, Dallas.
Morris, Julian H., Dallas.
Muirhead, E. E. (Mil.), Dallas.
Muirhead, Sam J. (Mil.), Dallas.
Murphy, Jos. B., Dallas.
Myers, David V., Dallas.
*Nash, C. C., Dallas.
*Nash, Tom M. (In.), Dallas.
Nelson, Harry E., Dallas.
Nelson, L. A., Dallas.
Nesbit, Harold T., Dallas.
Nesbitt, Irene T., Dallas.
Neuman, Albert, Dallas.
Newsom, Asa A., Dallas.
Newton, Cosette Faust, Dallas.
*Newton, Frank H., Dallas.
Nichols, Ace E., Dallas.
Nichols, Carl, Gladewater.
Nitsche, Ernest W., Dallas.
Nordenbrock, Gregory J., Dallas.
*Norman, Floyd A., Dallas.
*O'Brien, H. A., Dallas.
O'Brien, J. D., Dallas.
Ormsby, F. E., Dallas.
*Pace, John M., Dallas.
Park, Barton E., Dallas.
Parker, Edw. R., Dallas.
Parks, Harold D. (Mil.), Dallas.
Passamonte, Jane A., Dallas.
*Paternostro, Chas. J., Dallas.
Patterson, Casey E., Dallas.
Patterson, Cecil O., Dallas.
Payne, Virgil M., Jr. (Mil.), Dallas.
Peacock, Geo. E., Big Spring.
Pearcy, Frank, Dallas.
Pelphrey, Chas. F. (Mil.), Dallas.
Pence, Ludlow M., Dallas.
Perkins, Jack F., Dallas.
Peyton, Jno. B., Dallas.
Pickard, J. M., Dallas.
Pickett, Taylor T., Dallas.
Pickett, Walter F. (Mil.), Dallas.
Pierce, Jas. L., Jr., Dallas.
Porter, Geo. L., Dallas.
Portman, Robt. K., Dallas.
Potts, J. M., Dallas.
*Potts, W. H., Jr., Dallas.
Powell, Eugene V., Jr. (In.), Dallas.
Powell, Homer, Dallas.
Prejean, Oran V., Dallas.
Price, Harry S., Dallas.
Provence, Sally Ann, Dallas.
*Quinn, Lester H., Dallas.
Ray, Jas. H., Dallas.
Ramsdell, Robt. L., Austin.
Rattan, Paul M., Dallas.
Reagan, A. Morris, Dallas.
Reaves, L. M., Dallas.
Reddick, Walter G., Dallas.
*Reed, Emil P., Dallas.
Reuss, G. T., Dallas.
Richardson, Joe B., Dallas.
Richter, Paul A., Dallas.
Riddle, Penn, Dallas.
Riddler, G. A., Dallas.
Riley, Jos. G., Dallas.
*Rippy, Edwin L., Dallas.
Robertson, Geo. W. III, (In.), Brooklyn, N. Y.
Robertson, Jas. E., Dallas.
Robinson, Wayne T., Dallas.
Robinson, Wm. T. (In.), New Orleans.
Rogers, Fred T., Dallas.
Rogers, Paul A., Dallas.
Rosenthal, R. S., Dallas.
Ross, Edward S., Dallas.
Ross, Jas. K., Dallas.
Rosser, Curtice, Dallas.
Rothschild, Jos. E. (In.), Dallas.
Rounsaville, Jno. Q., Dallas.
Rouse, Milford O., Dallas.
Rowe, J. F., Dallas.
Ruckner, Jno. C. (In.), Dallas.
Rudnick, Leon R. (In.), Dallas.
Rumpf, Wm. H., Dallas.
Rushing, E. O., Dallas.
Sacher, Clarence B., Dallas.
Salmond, Paul H., Dallas.
*Sams, Lewis C., Dallas.
Sanders, Oscar Perdue, Dallas.
Scales, Jno. G., Dallas.
Scanland, Viola P., Dallas.
Schaefers, Jos. G., Jr., Dallas.
*Schenewerk, Geo. A., Dallas.
Schmaltz, Wm. F. (Hon.), Dallas.
*Schoch, Arthur G., Dallas.
Schoolfield, Ben L., Dallas.
Schreiber, Gus Jr., Dallas.
Schuessler, W. W. (Mil), Dallas.
*Schuett, Albert J., Dallas.
*Schwenkenberg, A. J., Dallas.
Scurry, Maurice M., Dallas.
Sebastian, F. J., Dallas.
Seely, Marcus S., Dallas.
Selecman, Frank A., Dallas.
Sellers, Lyle M., Dallas.
Shane, J. Howard, Dallas.
*Shannon, Hall, Dallas.
Shannon, Manning B. Jr., Dallas.
Shaw, Marie L. (In.), Dallas.
*Shaw, Robt. R., Dallas.
Shea, Genevieve C., Dallas.
Sheffield, Lloyd B., Dallas.
Shelburne, Samuel A., Dallas.
*Sheldon, Lawrence B., Dallas.
Shelmire, J. Bedford, Dallas.
Shelton, A. M., Dallas.
Shelton, Wm. P., Dallas.
Shields, Thos L., Dallas.
*Shiflett, Roland M. Jr. (In.) Dallas.
Shoecraft, Warren A., Dallas.
*Short, Robt. F., Dallas.
Shortal, W. W., Dallas.
Shuey, Chas. B., Dallas.
Sigel, Zundel, Dallas.
Simpon, Jas. A., Dallas.
Singleton, J. D., Dallas.
Skrivanek, Ervin J. (Mil.), Dallas.
Slaughter, Donald H., Dallas.
*Small, Andrew B., Dallas.
Smith, Chas. L., Dallas.
Smith, Lois Weir, Dallas.
Smith, Ralph C. (Mil.), Dallas.
Smith, Richard M., Dallas.
Smith, Sydnie G., Dallas.
Smith, Tom E., Dallas.
Smith, Vinney L., Dallas.
Smith, W. Edgar, Dallas.
Sorrells, C. C., Dallas.
Sowers, Harry B., Dallas.
Spangler, Davis, Dallas.
*Sparkman, Robt S., Dallas.
Spegal, Doris V., Dallas.
*Spence, Harry M., Dallas.
Stanley, Ed. S. (Mil.), Dallas.
Stein, Justin J., Los Angeles.
Stell, Cecil I. (Mil.), Dallas.
Stephenson, Jas. H., Dallas.
Stephenson, W. O., Dallas.
Stiles, J. C., Dallas.
Stiles, Wendel A., Dallas.
Still, Oscar W. (Mil.), Dallas.
Stone, M. P., Dallas.
Strother, E. B. (Hon.), Dallas.
Strother, Wm. K. Jr., Dallas.
Stuart, Samuel E., Dallas.
Super, A. R., Dallas.
Surratt, Robt. R. (In.), Dallas.
Suttle, Robt C., Dallas.
Sweeney, J. Shirley, Dallas.
Sykes, W. M., Dallas.
Sypert, J. R. (Hon.), Dallas.

Taber, Martin E., Dallas.
Talkington, Percy C., Dallas.
Tarrer, Jas. K., Dallas.
*Taylor, Harold E., Dallas.
Terrell, Alex W. Jr., Dallas.
Terrill, Robt. J. (In.), Dallas.
Terry, J. G. (Mil.), Dallas.
Thaggard, Alvin Jr. (In.), Dallas.
*Thomas, Paul J., Dallas.
Thomas, W. Maxwell, Dallas.
*Thomasson, Arthur R. Sr., Dallas.
Thomasson, Arthur R. Jr., Dallas.
Thompson, B. M., Irving.
*Thompson, L. S., Dallas.
Thornton, C. W., Dallas.
Tigertt, W. D. (Mil.), Dallas.
*Tittle, Guy A., Dallas.
*Tittle, Lloyd C., Dallas.
Tobolowsky, Nathan (Mil.), Dallas.
Tomkies, Jas. S., Dallas.
Touchstone, Jay L., Dallas.
*Trumbull, R. A., Dallas.
Tsukahara, Wm., Dallas.
Tubb, C. L., Dallas.
Uhler, Claude Irving, Dallas.
*Underwood, Geo. M., Dallas.
Van Duzen, Rex E., Dallas.
Vassallo, Alfred L. (Mil.), Dallas.
Vassallo, Harry R., Dallas.
Vermooten, Vincent, Dallas.
Vieaux, Julius W., Dallas.
Waddell, Otto Jay Jr., Dallas.
Walborn, Kenneth B., Fort Worth.
Waldman, Morris F., Dallas.
Walker, Horace G. (Mil.), Dallas.
Walker, Price M., Dallas.
Wallace, Gordon K., Dallas.
Ward, Ernest (Mil.), Dallas.
Warren, Chas. H., Dallas.
Wassermann, Eugene, Dallas.
Watkins, A. B., Seagoville.
Watkins, Dale V. (Mil.), Dallas.
*Watkins, Margaret, Dallas.
Watson, Claud E., Dallas.
Weaver, S. D., Dallas.
Webb, Robt. W. (Mil.), Dallas.
Webb, Sam Jr. (Hon.), Dallas.
*Weir, Earl F., Dallas.
Welch, Mark L. (In.), Boston, Mass.
Wells, J. T., Dallas.
West, Ann, Dallas.
Wharton, Turner A., Dallas.
White, Byrd E. Jr. (In.), Dallas.
White, C. V., Dallas.
*White, Edward, Dallas.
Whitis, Rufus (Hon.), Dallas.
*Whitten, Merritt B., Dallas.
*Wilkinson, Wallace B., Dallas.
*Williams, Edw. C. (Mil.), Dallas.
Williams, G. Raworth, Dallas.
Williams, Paul C., Dallas.
Williams, Thos. S., Dallas.
Willis, R. S., Dallas.
Winans, Henry M., Dallas.
*Winborn, Claude D., Dallas.
Windrow, Frank M. (In.), Dallas.
Winford, T. E., Dallas.
Winn, Robt. E. (Mil.), Dallas.
Winn, Watt W., Dallas.
*Witt, Guy F., Dallas.
Wolfe, Joseph, Dallas.
Wolff, Paul M., Dallas.
Wolford, Robt. B., Dallas.
*Woodard, Gay T., Dallas.
Woodard, Thad L., Dallas.
Woods, Ozro T., Dallas.
Woolf, Jack I., Chicago, Ill.
Worley, John R., Dallas.
Wright, Carleton C. (Mil.), Dallas.
*Wyvell, Dorothy B., Dallas.
*Wylie, John T., Dallas.
Yancey, R. S., Dallas.
Yarbrough, Doyce C. Jr., Dallas.
Young, John G., Dallas.
Zier, Jas. R. (In.), Brownwood.
Zuelzer, Wilhelm (Mil.), Dallas.

DELTA COUNTY MEDICAL SOCIETY

Blair, Samuel F., Cooper.
Janes, Olen G., Cooper.
Janes, Olen Y., Cooper.
*Janes, Osler Y., Cooper.
Lowry, David O. (Sec'y), Cooper.
Westerman, Daniel B. (Pres.), Cooper.
Wheat, E. Baxter, Daingerfield.

DENTON COUNTY MEDICAL SOCIETY

Allen, Jos. H., Justin.
Davis, Bert E., Denton.
Evans, Rebecca M., Denton.
Hayes, Lindley O., Denton.
Hinkle, Geo. W., Denton.
Holland, Martin L., Denton.
Hutcheson, Melvin L., Denton.
Kimbrough, Wallace C., Denton.
Magness, Wm. H. (Pres.), Denton.
Miller, Walter S. Jr., Denton.
Pierce, Willa Louise, Aubrey.
Short, Bobbye J. (Sec'y), Denton.
Sullivan, John M., Sanger.
Woodward, Jack, Denton.
Wyss, Albert E., Denton.

ELLIS COUNTY MEDICAL SOCIETY

Baker, Edmund F., Ennis.
Bodenhamer, Jas. G., Palmer.
Carlisle, F. H., Italy.
Chapman, John N., Ennis.
Clark, Jos. L., Ennis.
Cox. Arthur J. (Hon.), Arlington.
Curby, John H. (Pres.), Maypearl.
Donnell, Herbert, Waxahachie.
Dykes, A. O., Italy.
Estes, Ted G., Waxahachie.
*Gough, E. F., Waxahachie.
Harris, Jos. B., Midlothian.
Hastings, Miles E., Waxahachie.
Jackson, Walter B., Waxahachie.
Jenkins, F. H. (Hon.), Italy.
Jenkins, J. B., Waxahachie.
Jeter, Jas R., Ennis.
Jones, Jos. E., Waxahachie.
Killian, J. E., Milford.
Ledbetter, W. C., Ennis.
Story, Fred L., Ennis.
Tenery, Robt. M. (Sec'y), Waxahachie.
Tenery, W. C., Waxahachie.
*Thomas, A. L., Ennis.
Walker, Allan E., Ferris.
*Watson, S. H., Waxahachie.

FANNIN COUNTY MEDICAL SOCIETY

Biggers, Lawton C., Bonham.
Cappleman, James J., Honey Grove.
Cappleman, William P., Honey Grove.
Donaldson, James M. (Sec'y), Bonham.
Fry, Samuel D., Ladonia.
Kennedy, Alvis B. (Pres.), Bonham.
Lannius, John A., Bonham.
Leeman, Henry H., Windom.
Morgan, Lewie E., Bonham.
Risser, Joe A., Bonham.
Saunders, David J., Bonham.
Scates, Henry R., Bonham.
Sellers, Sidney P., Honey Grove.
Ward, Wm. Y., Ivanhoe.
Williams, Ethelbert C., Bonham.

GRAYSON COUNTY MEDICAL SOCIETY

Blassingame, W. Doak, Denison.
Bounds, J. W., Gunter.
Brown, H. L., Sherman.
Carraway, J. H., Sherman.
Carter, Wilbur, Sherman.
Cohen, M., Denison.
Collins, J. A., Gordonville.
Enloe, David C., Sherman.
Etter, Edward F., Sherman.
Fowler, F. F., Denison
Freeman, Don W. (Sec'y), Denison.
Freeman, William, Denison.
*Glecker, Arthur, Sherman.
Glecker, John D., Denison.
Greer, Guy W., Whitesboro.
Hailey, E. L., Denison.
Hardy, John, Sherman.
Henschen, G. E. (Hon.), Sherman.
*Jamison, David K., Denison.
Johnon, Clyde P., Whitewright.
*Klapproth, Herman, Sherman.
*Lee, W. A., Denison.
Levin, Samuel, Denison.
*May, Ross R., Whitewright.
Mayes, Jos. A. (Hon.), Denison.
McElhannon, A. M., Sherman.
McFarling, J. Everett, Denison.
Meek, Grover C., Whitesboro.
Norman, Lois L. (Pres.), Sherman.
Pierce, Paul L., Denison.
*Ridings, A. L., Sherman.
*Shelley, Jos. L., Howe.
Sneed, Archie G., Denison.
Southerland, W. I., Sherman.
*Sporer, Frank M., Van Alstyne.
Strother, C. D., Sherman.
Truett, Chas. B., Denison.
Tuck, Vernon L., Sherman.
*Woodward, Max R., Sherman.

HOPKINS-FRANKLIN COUNTIES MEDICAL SOCIETY

Chandler, Henry E., Mt. Vernon.
Daubs, Wm. H., Mt. Vernon.
*Fleming, Jas. M., Mt. Vernon.
*Hanna, Wm. Ray, Sulphur Springs.
Longino, S. Byrd, Sulphur Springs.
McConnell, T. H. (Pres.), Sulphur Springs.
Saunders, W. B., Sulphur Springs.
Stevens, Thos. H. (Sec'y), Sulphur Springs.
Stirling, Earl, Sulphur Springs.
Worsham, Archer B., Sulphur Springs.

HUNT-ROCKWALL-RAINS COUNTIES MEDICAL SOCIETY

Allen, Clarence G., Commerce.
Arnold, B. F., Greenville.
Becton, Edwin P., Greenville.
Becton, Joe, Greenville.
Bradford, Harry M., Greenville.
Bush, Wm. Leslie, Greenville.
Cheatham, J. C., Wolfe City.
Cooper, J. S., Greenville.
*Crim, E. T., Greenville.
Fain, G. Burton, Austin.
Goode, Emmett P., Greenville.
*Jenks, Ralph W., Greenville.
*Kennedy, Chas. T., Greenville.
King, H. E., Greenville.
King, Newell T., Commerce.
Leberman, Lowell H., Commerce.
*Maier, Henry W., Greenville.
Morrow, Wiley C., Greenville.
Peak, I. F., Greenville.
Pearson, Preston S., Celeste.
*Phillips, Wm. P., Greenville.
*Reeves, W. B., Greenville.
Roadman, Chas. H., Greenville.
Rogers, Harriet N. (Sec'y), Commerce.
Seyler, Louis W., Commerce.
Smith, Edgar E., Commerce.
Strickland, Thos. C., Greenville.
Trentham, J. C., Jr., Greenville.
Waller, L. T., Commerce.
*Ward, Jas. W., Greenville.
Whitmore, H. G., Wolfe City.
*Whitten, Samuel D. (Pres.), Greenville.

KAUFMAN COUNTY MEDICAL SOCIETY

*Alexander, Gough H., Terrell.
Alexander, Wm. F., Terrell.
Cockrell, Christopher C., Terrell.
Creel, Jane N., Dallas.
de Vlaming, William, Kaufman.
Friddell, Delmar T., Terrell.
Garrett, Wm. J., Terrell.
Hall, Edward I., Kaufman.
Holton, Robt. W., Terrell.
*Hudgins, David H. (Sec'y), Forney.
Jennings, Adolphys Y., Mabank.
Johnston, Lawrence W. (Pres.), Terrell.
Lane, Early D., Terrell.
Livingston, Edward N., Terrell.
Lyon, Floy E., Terrell.
Pollard, Willis J. (Hon.), Wichita Falls.
Poplin, Richard W., Terrell.
Powell, Geo. F., Terrell.
*Scarborough, Jas. W., Terrell.
Shands, Percy C., Mesquite.
Shaw, Guy G., Jr., Kaufman.
Sloan, Roy C., Terrell.
Smith, Landria C., Lockney.
Taylor, Harvey S., Kaufman.
Taylor, Homer A., Kemp.
Thomas, William M., Terrell.

LAMAR COUNTY MEDICAL SOCIETY

Armstrong, Jas. E., Paris.
*Armstrong, Jno. T. (Mil.), Paris.
Barker, Carl D., Paris.
Buford, Talma W., Pattonville Rt.
Byers, Lamar A., Paris.
Fitzpatrick, Wm. W., Paris.
Gilmore, Clarence E., Paris.
*Goolsby, Elbert, Paris.
Grant, Stephens H., Deport.
*Hammond, David Scott, Paris.
Hunt, Thos E. Jr. (Mil.), Paris.
Hunt, Thos. E. Sr., Paris.
Jennings, Jas. L., Roxton.
Johnson, Malcom L., Paris.
Kerbow, Dock F., Paris.
*Lewis, Robt. L. Jr. (Sec'y), Paris.
Lewis, Robt. L. Sr., Paris.
McCuistian, Lorenzo P., Paris.
McCuistian, Wm. W., Paris.
O'Neill, Owen R., Paris.
Parchman, Hugh W., Paris.
Powell, Jas. N., Paris.
*Robinson, Oscar W., Paris.
Stark, Ernest H., Paris.
Stephens, Jno. A., Paris.
Stephens, Luke B., Paris.
Townsend, Courtney M., Paris.
Walker, Marcellus A. Jr. (Pres.), Paris.
White, Hal H., Paris.

VAN ZANDT COUNTY MEDICAL SOCIETY

*Baker, Horace A., Wills Point.
Brandon, B. B. (Sec'y), Edgewood.
Cozby, V. B., Grand Saline.
*Cozby, Raymond W., Grand Saline.
Estes, Bates B., Canton.
Fry, Harry T., Wills Point.
Garland, W. L. (Pres.), Grand Saline.
Sanders, D. Leon, Wills Point.

WOOD COUNTY MEDICAL SOCIETY

Black, Wm. T., Quitman.
Buchanan, Alfred P., Mineola.
Burrus, R. E., Winnsboro.
Mathis, Jas. R., Mineola.
McDaniel, Adolphus A., Mineola.
Peterson, Thos. H. (Pres.), Mineola.
Reed, Thos. B. (Sec'y), Mineola.
Robbins, Virgil E., Quitman.
Wheeler, Frank B., Winnsboro.

FIFTEENTH OR NORTHEASTERN DISTRICT

Dr. C. A. Smith, Texarkana, Councilor.

BOWIE COUNTY MEDICAL SOCIETY

Baskett, Roy F., Texarkana.
*Collom, S. Allen Jr., Texarkana.
Cross, Ralph C., Texarkana.
Frank, Charles H., Texarkana.
Fuller, Theron E., Texarkana.
Good, Louis P., Texarkana.
*Hibbitts, William, Texarkana.
*Jones, Jno. W., Texarkana.
Middleton, B. C., Texarkana.
Parson, Geo. W., Texarkana.
Priest, Perry D., Texarkana.
Rives, Jno. H. (Pres.), Texarkana.
Roberts, Anon Warren, Texarkana.
Robinson, Jas. T., Texarkana.
*Smith, Chas. Adna, Texarkana.
*Spinka, Frances P., Texarkana.
Stuart, Chas. C. (Sec'y), Texarkana.
Tyson, Joe E., Texarkana.
Webbe, Robert S., Texarkana.
White, Jasper N., Texarkana.

CAMP COUNTY MEDICAL SOCIETY

Bates, J. K. (Sec'y), Pittsburg.
Johnson, R. L., Pittsburg.
Lacy, Robt. Y. (Pres.), Pittsburg.
Mitchell, J. H., Pittsburg.
Reitz, P. A., Pittsburg.

CASS-MARION COUNTIES MEDICAL SOCIETY

Allen, Jas. I., Bloomburg.
Brooks, Jesse M., Atlanta.
Brooks, Marshall J. Jr., Atlanta.
Campbell, Jas. H. (Mil.), Linden.
Davis, Chas. E., Linden.
Grumbles, Ernest W., Atlanta.
Hartzo, Jas. D., McLeod.
Jenkins, Homer L. D., Hughes Springs.
Jenkins, M. T. (Mil.), Hughes Springs.
*Nichols, Joe D., Atlanta.
Roach, Felton R., Queen City.
Starnes, Adolphus E., Hughes Springs.
Taylor, Orval R., Linden.
*Terry, Wm. S. Jr. (Pres.), Jefferson.
Woods, Andrew J. (Sec'y), Jefferson.

GREGG COUNTY MEDICAL SOCIETY

Adams, Chas. C., Longview.
Adams, Joe E., Kilgore.
Allums, Loraine L., Kilgore.
Andres, Ben, Longview.
Awalt, Elmer W., Longview.
Colvin, Paul V., Longview.
Cook, Hardy, Longview.
Crawford, Ralph C., Longview.
Downs, Seth R., Kilgore.
Elkins, Oliver W., Longview.
Farrar, Wm. P., Longview.
Ferrell, Marjorie C., Longview.
Fleming, John W., Jr., Kilgore.
Hancock, A. R., Gladewater.
Hardwick, Robt. S., Longview.
Hunter, Buel R., Seagraves.
*Hurst, V. R., Longview.
Jackson, Carl C., Longview.
Jones, E. L., Longview.
*Leake, Bain, Gladewater.
*Marchman, O. M., Jr., Dallas.
Markham, Louis N., Longview.
McKean, J. C., Gladewater.
McKellar, G. G., Longview.
McRee, J. T., Longview.
Moser, Emil R., Gladewater.
Moulder, Max K., Longview.
*Niehuss, Henry H., Longview.
*Phillips, James W., Longview.
Price, R. O., Kilgore.
Rhodes, Geo. V., Kansas City, Mo.
Roberts, J. D., Longview.
Ross, H. A., Longview.
Routon, Wm. Mack, Kilgore.
Rushing, Garland S., Longview.
Simmons, D. C., Kilgore.
Stratton, F. L., Kilgore.
Swinney, B. A., Longview.
Tate, Geo. W. (Sec'y), Longview.
Van Beber, J. A., Gladewater.
Van Sickle, R. J., Longview.
Velinsky, Morris, Kilgore.
Vines, C. L., Kilgore.
Watkins, E. O. (Pres.), Greggton.
Wensley, John E., Longview.

HARRISON COUNTY MEDICAL SOCIETY

Baldwin, Jno. B., Marshall.
Bennett, Wm. H., Marshall.
Box, Otho H., Marshall.
Carter, Ray H., Marshall.
Cocke, Rogers C., Marhall.
Davis, Carroll C., Marshall.
Granbery, R. G. (Mil.), Marshall.
Harris, Jas. H. (Sec'y), Marshall.
Heidleberg, Chas. H., Marshall.
Hill, Jno. E., Marshall.
Holcomb, N. F., Marshall.
Littlejohn, Frank S., Marshall.
McCurdy, Carl, Marshall.
Mondrick, Frank V., Marshall.
Phillips, Arch J., Marshall.
Redding, L. M., Marshall.
Rice, Lee Roy, Marshall.
Tenney, Samuel W. (Pres.), Marshall.
Vaughn, Herbert H., Waskom.
Wyatt, Chas. A., Marshall.

MORRIS COUNTY MEDICAL SOCIETY

Baber, Dunbar R., Daingerfield.
Jenkin, Don Juan, Daingerfield.
Moore, Rufus D. Jr., Omaha.
Smith, William (Sec'y), Naples.
Truitt, Crawford S., Daingerfield.

RED RIVER COUNTY MEDICAL SOCIETY

Butts, Thomas R., Annona.
Marx, Melvin Jr. (Pres.), Clarksville.
Payne, Ross W., Clarksville.
Reed, Charles B. (Sec'y), Clarksville.
Watson, Nowlin, Clarksville.
Wright, James L., Clarksville.

TITUS COUNTY MEDICAL SOCIETY

Bassett, T. R., Mt. Pleasant.
Ellis, John M., Mt. Pleasant.
Ellis, Jno. M. Jr. (Mil.), Mt. Pleasant.
Grissom, Thos. S. (Pres.), Mt. Pleasant.
Holland, Jno. III (Mil.), Mt. Pleasant.
Smith, A. A., Talco.
Taylor, Willis A. (Sec'y), Mt. Pleasant.
Taylor, Wm. A., Mt. Pleasant.

UPSHUR COUNTY MEDICAL SOCIETY

*Childress, Harmon J., Gilmer.
*Daniels, Jno. G., Gilmer.
Fenlaw, Jos. L. (Pres.), Gilmer.
Marshall, Thos. E., Gilmer.
*Ragland, Hugh M. (Sec'y), Gilmer.
Ragland, Madison S., Gilmer.

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Vol. XLII **July, 1946** **No. 3**

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION AND PUBLIC HEALTH IN TEXAS

The Stand of Texas Congressional Candidates on Socialized Medicine and the Wagner-Murray-Dingell Bill.—Members of the State Medical Association of Texas, comprising perhaps 90 per cent of the reputable white physicians of Texas in active practice, have an unique opportunity here to become informed of the position of Texas candidates for Congress on subjects vital to the medical profession and the public.

Under date of June 20, 1946, a letter was individually addressed by the Secretary of the State Medical Association of Texas, to all candidates for the U. S. Congress who had announced their candidacies by that date, asking for a statement for publication regarding their attitude toward socialized medicine and the Wagner-Murray- Dingell bill in particular. The names of candidates were secured from the Texas Legislative Service and newspaper clippings. Addresses were difficult to secure, and in some instances could not be found. There are listed here only the names of candidates whose addresses could be obtained, and the statements of all who responded to the State Secretary's letter.

It will be noted that the names of all candidates (whose addresses were secured) are listed under the Congressional office they seek, with the counties represented by that office in the Congress.

It is urged that particular attention be given not only to the statements furnished by the candidates, *but to the omission of statements from some of them.* While it cannot be assumed that such omission places a candidate in support of the socialization of medicine, it certainly points the finger of doubt at him.

It will be further noted that ten incumbents who have previously furnished unequivocal statements of opposition to socialized medicine and the Wagner-Murray-Dingell bill[1, 2] have opposition in the coming primaries. Medicine will do well to consider seriously this fact. Labor, and particularly the C. I. O. and its Political Action Committee, have been active in Texas in connection with Congressional races. While we do not believe the rank and file of Texas labor is for socialized medicine and the Wagner-Murray-Dingell bill, both the American Federation of Labor and the Congress of Industrial Organizations have appeared as strong proponents at recent hearings on the Wagner-Murray-Dingell bill in the present Congress.

The letter addressed to candidates for Congress by the State Secretary and the replies received follow:

"The many physicians resident in your Congressional District, in which you are a candidate, would appreciate receiving your opinion in regard to the legislation now before Congress which seeks to socialize medicine in the United States. Any information you will be kind enough to give us will be published in the next edition of the TEXAS STATE JOURNAL OF MEDICINE so that all doctors may be fully advised.

"In particular the doctors would like to know how you stand on the Wagner-Murray-Dingell bill, which provides compulsory health insurance, regiments all doctors, and imposes a huge additional tax burden on the people of America.

[1]Views of Texas Congressmen on 1945 Version of Wagner-Murray-Dingell Bill (Ed.), Texas State J. Med. 41:282-285 (Oct.) 1945.

[2]Views of the Texas Congressmen on the 1945 Wagner-Murray-Dingell Bills (Ed.), Texas State J. Med. 41:391-392 (Dec.) 1945.

"So that you may be fully conversant with the attitude of Texas doctors concerning this Federal legislation, we enclose a reprint of an editorial published in the May, 1946, number of the TEXAS STATE JOURNAL OF MEDICINE.

"We will appreciate a reply at your earliest convenience."

CANDIDATES FOR U. S. SENATOR FROM TEXAS

Tom Connally, Washington, D. C. (incumbent).
A. B. (Cyclone) Davis, Dallas.
Terrell Sledge, Kyle.
Laverne Somerville, Dallas.

Excerpts of answers received from candidates for the office of U. S. Senator from Texas follow:

ARLON BARTON (CYCLONE) DAVIS, JR., Dallas: "Anything socialistic is too utopian for the modern day. I am not only opposed to compulsory health insurance, including the Wagner-Murray-Dingell bills, but I am unalterably opposed to any form of compulsion by the self appointed, self opinionated political and financial godfathers of the country; believing with Thomas Jefferson that a people 'is the best governed who is the least governed'."

TERRELL SLEDGE, Kyle: "In my opinion it would be tragic if the doctors of Texas, individually fine as they are, take a collective stand against a bill so well conceived in the public interest, and so bitterly needed by the poor folks & farmers of Texas, as the M-W-D bill, or one like it. Why not help us figure out a better bill? You can if you but will, & you doctors will profit most of all of us."

It should be pointed out here that the incumbent, the Hon. Tom Connally, of Texas, was in Paris, France, in attendance on the Big Four Ministers Council of the United Nations at the time the above letter was addressed to Congressional candidates and there has been no opportunity for him to receive the letter and to furnish a statement. His record for American medicine in the past has been four square.

CANDIDATES FOR TEXAS REPRESENTATIVE IN THE U. S. CONGRESS BY CONGRESSIONAL DISTRICTS

When the first Wagner-Murray-Dingell bill was introduced in the present Congress in 1945, statements were requested by the Secretary of the State Medical Association of Texas from all Texas Congressmen regarding their attitude toward socialized medicine in general and the Wagner-Murray-Dingell bill in particular. Statements were received from practically all and were published in an editorial in the October, 1945, JOURNAL (pages 282-285). It was deemed unnecessary to request Congressmen who furnished such statements to do so again. Their statements, however, are republished here, and indication is given of their previous publication.

DISTRICT 1

(Bowie, Cass, Delta, Franklin, Harrison, Hopkins, Lamar, Marion, Morris, Red River, Titus Counties)

Shelburne H. Glover, Texarkana.
Wright Patman, Texarkana (incumbent).
Henry L. Ray, Paris.

WRIGHT PATMAN,[1] Texarkana: "The Wagner-Murray-Dingell bill is a very long comprehensive measure. It involves many different issues, as I understand it. One is the question of medicine and hospitalization. I want you to know that I am opposed to any legislation that will deprive any patient of the right to select his own doctor, his own nurse, or his own hospital. In other words, Doctor, I am opposed to socialized medicine."

H. L. RAY, Paris: "In regard to the question asked on the bill called socialized medicine, in my opinion this is strictly a communist bill which I am strictly against."

DISTRICT 2

(Angelina, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Sabine, San Augustine, Shelby, Tyler Counties)

J. M. Combs, Beaumont (incumbent).
G. M. Stephens, Beaumont.
Hugh A. Wilson, Port Arthur.

J. M. COMBS, Beaumont: "In December (1945) while in Texas, I made a public statement in opposition to Socialized Medicine and I'm not going to support any bill which will deprive the individual of his right to choose his doctor, nor will I vote to 'regiment' the great medical profession.

"My stand has not changed since that statement was made, and you may count on my continued support in opposition to the Wagner-Murray-Dingell bill."

G. M. STEPHENS, Beaumont: "The freedom of the Medical Profession from Government regulations should be guarded very zealously by all who appreciate the freedom to worship in the church of their choice.

"If I am elected to Congress I shall not only vote against this Wagner-Murray-Dingell bill, but I will fight it with all the power that God places at my command—it and any and all other bills that seek to hobble the Medical Profession or any other of our cherished American principles of government."

HUGH A. WILSON, Port Arthur: "Although I do not think the bill will give a sufficiently large number of people an opportunity to obtain good medical services, or that it fills all the requirements for good health (which the authors of the bill do not claim it does), I do think it is about the best possible arrangement under the circumstances. The bill does make an attempt to preserve the maximum possible freedom for the patient and physician under a medical service system partly supported by the taxpayer.

"My main interest and effort is to improve our economic system, but in the absence, at the present time, of an effective national effort for that purpose, I support the Wagner-Murray-Dingell Bill as a second choice."

DISTRICT 3

(Camp, Gregg, Panola, Rusk, Smith, Upshur, Van Zandt, Wood Counties)

Lindley Beckworth, Gilmer (incumbent).
D. S. Meredith, Jr., Longview.
Earl Roberts, Longview.

LINDLEY BECKWORTH,[1] Gilmer: "Thank you for your letter of August 2. As I have written you before, I do not favor socialized medicine. I feel the doctors have done a wonderfully fine job of work."

D. S. MEREDITH, JR., Longview: "I am unalterably opposed to socialized medicine and the Wagner-Murray-Dingell Bills. Certainly, under the Constitution of the United States, we should be free to select a doctor of our own choice and should not be dictated

[1]Views of Texas Congressmen on 1945 Version of Wagner-Murray-Dingell Bill (Ed.), Texas State J. Med. 41:282-285 (Oct.) 1945.

to by our national government with respect to so personal and private a matter as the selection of our physician."

EARL ROBERTS, Longview: "In answer to your inquiry of June 20th, I wish to advise that I am opposed to the Wagner-Murray-Dingell bills which provide compulsory health insurance and regimentation of all doctors. I am opposed to any type of political regimentation of the medical profession.

"I, too, am a member of a profession and certainly I would oppose any effort on the part of the Federal Government to regiment my practice of law."

DISTRICT 4

(Collin, Fannin, Grayson, Hunt, Kaufman, Rains, Rockwall Counties)

The Hon. Sam Rayburn, of Bonham, incumbent, is without opposition. Physicians of the Fourteenth District assert Mr. Rayburn may be depended upon to uphold the views of American medicine.

DISTRICT 5

(Dallas County)

William Burrow, Dallas.
W. C. Graves, Dallas.
Sarah T. Hughes, Dallas.
Preston P. Reynolds, Dallas.
J. Frank Wilson, Dallas.

WILLIAM BURROW, Dallas National Bank Bldg., Dallas: "I am pleased also to be able to tell you that the opening radio address of my campaign included a talk by Dr. Samuel A. Shelburne of Dallas, in which he explained why I felt the Murray-Wagner-Dingell bill would be harmful to the health, welfare, and happiness of the people of Texas.

"In plain, unmistakable words, my platform, upon which I seek election to the office of United States Congressman, states, 'I am against power of government to regiment doctors.'

"If I should personally get sick, I should want a regular physician to treat my illness. And I feel that regular, practicing physicians should treat the ailments and diseases of the people of Texas, and should guide us in all health plans."

W. C. GRAVES, Dallas: "I wish to state that I am definitely opposed to the Wagner-Murray-Dingell Bills, and any other kind of Medical set-ups which are fostered by Sidney Hillman, and other radical groups to put this nation on State Socialism."

J. FRANK WILSON, Dallas: "I have just finished writing every doctor, both medical and dental, in Dallas County, telling them of my stand against the Wagner-Murray-Dingell bills. I am unalterably opposed to any character or kind of socialized medicine or the centralization of any other groups.

"I am also fighting the Political Action Committee and its leaders, who are seeking to change our form of government from a representative democracy to a state socialism or to communism. Surely the doctors and other groups of taxpaying citizens will wake up during this campaign and wield their powerful influence against those who seek to destroy us."

DISTRICT 6

(Brazos, Ellis, Freestone, Hill, Leon, Limestone, Navarro, Robertson Counties)

Joe Cowley, Hillsboro.
Lynn B. Griffith, Waxahachie.
Fountain Kirby, Groesbeck.
Olin E. Teague, College Station.
Tom L. Tyson, Corsicana.

JOE COWLEY, Hillsboro: "I have written several of the County Medical Associations in the Sixth Congressional District denouncing any form of Socialized Medicine. The reasons for my opposition are numerous . . . One of these reasons is that our State Constitution says that the State Legislature shall make the laws controlling the practice of Medicine. I am opposed to over-riding the Constitution of this state by Federal statutes.

"Germany had socialized medicine and I feel sure that the people of this nation are opposed to any legislation that would tend to lead to that end.

"I am also opposed to the Wagner-Murray-Dingell bill, as I feel it would only work a hardship on the Doctors as it would involve red-tape which we have too much of already."

LYNN B. GRIFFITH, Waxahachie: "To the medical profession I will say that I am not only opposed to socialized medicine but am opposed to socialism in all forms. That, however, should not prevent the government from aiding and assisting the medical profession in research. We do not need socialism.

"The Wagner-Murray-Dingell bill which provides compulsory health insurance will of a necessity regiment all doctors. This would be but step number one to regiment all professional people. Once this is done, we can forget our democracy and turn to Russia for guidance. Legislation of this type admits that a democracy is not the best type of government and that our people are not capable of caring for themselves.

"Compulsory insurance as set out in the Wagner-Murray-Dingell bill would promote more bureaus, more red tape, and more money for the taxpayer to pay, while voluntary insurance would give private enterprise an opportunity to develop at less expense and with no red tape or bureaus a sound program of insurance for those people who desire it."

FOUNTAIN KIRBY, Groesbeck: "I am very much opposed to the Wagner-Murray-Dingell bill and any other bill that attempts to socialize medicine, control the use thereof or interfere with the practice of medicine or dentistry. When I need a dentist I want one of my own choice and if I need a doctor I want one of my own choice and not one furnished by some 'bureaucrat.'

"I might add that I am bitterly opposed to any interference with local affairs by the Federal Government. I am an old fashioned Democrat . . . I am a strict believer in the Constitutional form of government that we are supposed to have strict allegiance to the honor principles of the Democratic Party and teachings of Thomas Jefferson."

OLIN E. TEAGUE, College Station: "I do not believe in socialized medicine. There are some sections of the Murray-Wagner-Dingell bill to which I do agree but which I will not discuss here. There are three to which I do not agree and if elected I will never vote for a bill which includes these three: (1) compulsory health insurance, (2) regimentation of doctors, (3) any attempt to tell a family which doctor they must use. I believe the right to choose your own doctor is one right you could never take from the American people by any law; they would not stand for it. I sincerely believe in voluntary prepaid health insurance."

TOM TYSON, Corsicana: "I shall never vote for any bill which would impair the voluntary and confidential relationship between physician and patient.

"I am for ample support and wide extension of public health units and agencies, whereby the federal government, in coöperation with our scientists and our philanthropists, has virtually eliminated many diseases which were formerly the bane of human existence."

". . . members of your great and noble profession may be sure that I will not vote for any measure affecting your profession unless it is supported by the reputable doctors of my District and State."

DISTRICT 7

(Anderson, Cherokee, Grimes, Henderson, Houston, Madison, Montgomery, Nacogdoches, Polk, San Jacinto, Trinity, Walker Counties)

The Hon. Tom Pickett, of Palestine, incumbent, is without opposition. He has expressed his opposition to socialized medicine and the Wagner-Murray-Dingell bill.[1]

DISTRICT 8

(Harris County)

S. T. Brogdon, Houston.
O. Bert Horne, Houston.
Charles E. Kamp, Houston.
Albert Thomas, Houston (incumbent).

Not a single candidate from the Eighth Congressional District has furnished a statement for publication regarding the Wagner-Murray-Dingell bill or socialized medicine. This fact presents a challenge to the medical profession of this district.

DISTRICT 9

(Austin, Brazoria, Calhoun, Chambers, Colorado, Fayette, Fort Bend, Galveston, Goliad, Jackson, Lavaca, Matagorda, Victoria, Waller, Wharton Counties)

Ben H. Faber, Eagle Lake.
C. O. Foerster, Jr., Richmond.
Clyde B. Kennelly, Rosenberg.
J. J. Mansfield, Columbus (incumbent).
L. J. Sulak, La Grange.
Clark W. Thompson, Galveston.

C. O. FOERSTER, JR., Rosenberg: "I have at all times believed in the freedom of our Democratic manner in making a livelihood. Personally I am opposed to the Wagner-Murray-Dingell bill and the Hill-Burton bill and any other (such) bill . . . and if I am elected as Congressman from my District, your association and the medical men of our country may feel free to call upon me in opposing any legislation that might be submitted that bears any resemblance to regimentation or socialized medicine. I shall use my influence and my ability to defeat any such legislation . . ."

J. J. MANSFIELD,[1] Columbus: "I have your letter of August 2nd and in reply, will say that I am opposed to the provisions of the so-called Wagner-Murray-Dingell bill. It does not seem likely that this proposal will come before the House during the present session, but if it should, I shall oppose it."

L. J. SULAK, La Grange: "As to the Wagner-Murray-Dingell bill I beg to say that I have not studied the bill; therefore, I should not say that I am for or against it. However, I have read considerable discussion of same, and, if these discussions are correctly based, I would naturally oppose it for I am opposed to socialism or communism in any form, and I do not like the word compulsion.

"You state in your letter that the purpose of the bill is 'compulsory health insurance, regiments all doctors, and imposes a huge additional tax burden on the people of America.'

"If that is correct, and I take it that it is, then I am opposed to the bill. I certainly do not like regimentation of doctors any more than I do of farmers or any other group. I have many times condemned regimentation of farmers to their and the country's detriment. I might also say that I am opposed to some federal agency selecting my family doctor for me."

The medical profession of the Ninth Congressional District will approve of Mr. Sulak's statement regarding regimentation of doctors. They will, however, recall that Mr. Sulak was a leader for cult legislation while in the State Senate.

CLARK W. THOMPSON, Galveston: "I am, and have always been, opposed to socialized medicine. If I were now in Congress, I would vote against any legislation which provided for any sort of regimentation of doctors and compulsory health insurance.

"As a matter of fact, I am opposed to regimentation of any sort in normal times. I like free enterprise, and a system by which an individual may profit in accordance with his ability and initiative. I expect that makes me an old-line Democrat."

DISTRICT 10

(Bastrop, Blanco, Burleson, Burnet, Caldwell, Hays, Lee, Travis, Washington, Williamson Counties)

Hardy Hollers, Austin.
Lyndon Johnson, Austin (incumbent).
Charles E. King, Austin.

HARDY HOLLERS, Austin: "I am opposed to the Wagner-Murray-Dingell Bills . . .

"I am opposed to the effort to establish socialized medicine in this country. If I am elected to Congress, I will do everything within my power to defeat legislation which is now pending and any that may hereafter be introduced having as its purpose, either directly or indirectly, the socialization of medicine.

"I favor liberal support of the public health service. Its activities, however, should be in the field of advancing public health and preventive medicine. I am opposed to any program whether it be socialized medicine or otherwise which is designed to subject the medical profession to either control or supervision by the public health service."

LYNDON JOHNSON,[1] Austin: "I have your letter of August 2nd, together with the resolution passed by the State Medical Association in opposition to the Wagner-Murray-Dingell bill.

"I have tried to make my position with reference to this legislation clear to everyone in my district, and I have seen no reason to change the attitude I expressed last year, which was that I was opposed to the bill, and that in the event it was presented to Congress for action I planned to fight it with every facility at my command."

DISTRICT 11

(Bell, Bosque, Coryell, Falls, McLennan, Milam Counties)

The Hon. W. R. Poage, of Waco, incumbent, is without opposition. It is pleasing to record that Mr. Poage has expressed definite opposition to the Wagner-Murray-Dingell bill and socialized medicine.[1]

DISTRICT 12

(Hood, Johnson, Parker, Somervell, Tarrant Counties)

H. C. Allison, Fort Worth.
Lindsley M. Brown, Arlington.
Byron Buckeridge, Fort Worth.
Goldman Drury, Fort Worth.
Earnest O. Gillam, Fort Worth.

[1]Views of Texas Congressmen on 1945 Version of Wagner-Murray-Dingell Bill (Ed.), Texas State J. Med. 41:282-285 (Oct.) 1945.

[1]Views of Texas Congressmen on 1945 Version of Wagner-Murray-Dingell Bill (Ed.), Texas State J. Med. 41:282-285 (Oct.) 1945.

A. E. Harding, Fort Worth.
Penn J. Jackson, Cleburne.
Wingate Lucas, Grapevine.
Ernest May, Fort Worth.
Curtis McBroom, Fort Worth.
Walter A. Nelson, Fort Worth.

H. C. ALLISON (chiropractor), Fort Worth: "If elected to Congress I will not be passive . . . but will throw everything I have into the battle against any kind of legislation that attempts to place the doctor and the patient under too much government supervision. I am viciously opposed to the Wagner-Murray-Dingell bill now pending in Congress . . . It will be my purpose and my pleasure to fight all such legislation in the national Congress of our country."

LINDSLEY M. BROWN, Arlington: "I know I could never be satisfied with a doctor who was just picked out at random, some man that maybe I had never heard of, by some card index system to be sent by an office boy to my home to serve me or my loved ones when we are sick.

"I could never vote for socialized medicine. I want to always have the right to select my own doctor and I want him to be my personal friend in whom I have confidence because I want to be able to look him in the eye as my friend and have confidence in him as my friend because of my personal knowledge of his well trained ability known to me as a man whom I can depend upon to tell me the truth. I want my own family physician to look after both me and my family, because when the shadow of death comes stalking 'bout my home and I want some one on earth on whom I can lean, as well as my Savior in heaven. I need him in the hour of trouble and I don't want an office boy to choose him for me."

BYRON BUCKERIDGE, Fort Worth: "As a veteran I declare that unless the Wagner-Murray-Dingell bills pass, you who are lobbying against it will force veterans to push through a health program for veterans and their families only. Such action will be followed by veterans pressure action in housing, bonuses, employment, and other fields where selfish interests are blocking the extension of democracy to all of the people.

"Obviously, in Texas at least, there are no great leaders in the medical profession today to compare with Eric Johnston, Chester Bowles, Henry Kaiser and Henry Wallace.

"I came too close to German 88's in the battles for Italy to fear losing the total vote of the members of your association. I will not compromise during this campaign, nor during my lifetime, on my fight to extend social security to include health for the American people."

GOLDMAN DRURY, Fort Worth: "I am against socialized medicine and I believe the working man will also be against it if he takes time to analyze its true meaning in providing a way for the drones to live off the wages of the honest laborer."

EARNEST O. GILLAM, Fort Worth: "Replying to yours of June the twentieth, will say that I am definitely AGAINST the Wagner-Murray-Dingell bill, which provides compulsory health insurance and other associated provisions in socialized medicine.

"I am against ANY legislation of a Federal nature that tends to centralize power in Washington and believe the powers should be returned to the individual states in matters of this kind to be dealt with locally."

A. E. HARDING, Fort Worth: "In regard to the socialized medicine bill before the United States Congress at this time, known as Senate Bill 1606, Wagner-Murray-Dingell Bill, which proposes to regulate the Medical Associations in Texas as well as the Nation and place the United States Government in the medical profession; you may feel assured that I am strictly opposed to such a measure which has within itself the regulation of all doctors and their profession in this country.

"As you know, my record as Representative in the Texas Legislature, was that I always supported the medical profession in the highest degree and opposed any measures that would hamper the advancement of medical science."

PENN J. JACKSON, Cleburne: "Thanks for your inquiry as to my stand on the Wagner-Murray-Dingell bills, in view of my candidacy for Congress.

"I am definitely against these bills or any attempt to regiment the doctors or anybody else. We have too much regulation from Washington already."

WINGATE H. LUCAS, Fort Worth: "I am opposed to the Wagner-Murray-Dingell Bill, and any other form of Socialized Medicine. I shall not only vote against such a bill but I shall work against any legislation of this character. In my opening address at Grapevine, Texas, I announced my opposition to this and kindred proposals.

"The medical profession is best qualified to determine what legislation, if any, should be enacted affecting the profession. I shall be advised regarding such matters by the physicians in my District in whom I have the utmost confidence."

ERNEST MAY, Fort Worth: "My impression of the Wagner-Murray-Dingell bill, gained from only casual examination, is that it would lengthen the red tape which already ensnares American life. I am opposed to any measure so involved, apparently, that it would not be comprehensible to the average citizen; and I am opposed to any measure which sets up a new bureaucracy.

"In my opinion, no public health measure should be adopted without general approval of the medical profession. Upon proposed legislation affecting care of the public health, I should take counsel of physicians, who seem almost unanimous in opposition to the pending bill."

CURTIS MCBROOM, Fort Worth: "I am opposed to the Wagner-Murray-Dingell bill as I am opposed to the creation of any other bureaucratic bills. My father was a country doctor so I am personally familiar with many of the problems of the medical profession. I realize that in these times we do need a national health program such as has been proposed by the AMA. I heartily favor Federal coöperation with the AMA to the end that we may have a healthy America."

WALTER A. NELSON, Fort Worth: "I acknowledge with thanks, the receipt of your letter of June the 20th, asking my position upon Socialized Medicine and the Wagner-Murray-Dingell bills, and I hasten to say that I am opposed to Socialized Medicine in every form, and so announced in my preliminary announcement for Congress. I have followed that announcement with an ordinary postal card to each doctor in the district stating my position upon the question. My direct answer is that I am opposed to the Wagner-Murray-Dingell bills, and Socialized Medicine and all other forms of socialism . . . I am sure my position upon Socialized Medicine is for the best of the country, as well as the medical profession."

DISTRICT 13

(Archer, Baylor, Clay, Cooke, Denton, Foard, Hardeman, Jack, Knox, Montague, Throckmorton, Wichita, Wilbarger, Wise, Young Counties)

John R. Good, Quanah.
Ed Gossett, Wichita Falls (incumbent).
Houston McMurry, Henrietta.
Mack Taylor, Wichita Falls.

JOHN R. GOOD, Quanah: "I do not know of any

reason why the doctors of the United States should be regimented; surely they have not faltered in their duties to the public.

"It is characteristic of those who take charge of anything to issue the orders. Independent opinion does not flourish under such conditions. Medical science has made wonderful progress under conditions which have permitted freedom of action. The confusion which would result from an adverse governmental action would not bode well for the future and future possibilities have a persistent way of turning into present realities.

"I am not familiar with the text of the Wagner-Murray-Dingell bills, but I am opposed to laws that would regiment our doctors or socialize medicine."

ED GOSSETT,[1] Wichita Falls: "I have just got back to my office after some weeks absence and find your letter of August 2.

"I believe I have heretofore written you of my opposition to socialized medicine. I have expressed this opinion on many occasions. I certainly am not in favor of the Wagner-Murray-Dingell bill about which you have written. I am a strong devotee of our American system of free enterprise and individual action. I have long said the greatest immediate threat to general welfare on the domestic front is the growing size, cost, and activity of the federal government. We shouldd shun as a plague any and everything which rewards indolence and penalizes diligence, or seeks to destroy the individual initiative of the average American citizen."

MACK TAYLOR, Wichita Falls: "Having been in the retail and wholesale drug business practically all my life you could hardly expect me to be other than for the doctors, nurses, and druggists."

DISTRICT 14

(Aransas, Atascosa, Bee, Brooks, Comal, DeWitt, Duval, Gonzales, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, McMullen, Nueces, Refugio, San Patricio, Wilson Counties)

The Hon. John E. Lyle, of Corpus Christi, incumbent, is without opposition. Mr. Lyle has recorded his opposition to socialized medicine and the Wagner-Murray-Dingell bill.[1]

DISTRICT 15

(Cameron, Dimmit, Frio, Hidalgo, Jim Hogg, La Salle, Maverick, Medina, Starr, Webb, Willacy, Zavala Counties)

J. T. Ellis, Jr., Weslaco.
Milton H. West, Brownsville (incumbent).
William Henry Yeager, Hebbronville.

J. T. ELLIS, JR., Weslaco: "Replying to your letter of inquiry of June 20th, regarding my opinion of the legislation now before Congress which seeks to socialize medicine in the United States, my opinion can be stated in just a few words: I am opposed to this measure and any subsequent measures which may be introduced which seek the same end."

MILTON H. WEST,[1] Brownsville: "This will acknowledge your letter of September 21, requesting me to advise you as to my position in regard to the Wagner-Murray-Dingell bills, which have been introduced in Congress.

"For your information, I am opposed to socialized medicine—have consistently opposed legislation of a socialistic nature, and as long as I am in office I expect to do my utmost to defeat legislation of this type.

"Incidentally, you might be interested to know I am receiving some very severe criticism of the medical men and their method of operation—not from the average citizen, but from professional men, which is a surprise to me."

W. H. YEAGER, Hebbronville (written for Mr. Yeager by Cameron C. Stineman, The Yeager for Congress Committee): "Mr. Yeager feels very definite about the Wagner-Murray-Dingell bills. He is definitely against them. In his Congressional District, Henry Yeager enjoys the friendship and backing of many leading physicians. He has discussed this bill with them in detail. And he has seen as clearly as they that this bill would work a great injustice not only to the medical profession, but also to the average man.

"We would greatly appreciate your informing every reader of your excellent publication that, if elected next July 27th, Henry Yeager will exert every effort in his power to defeat this bill—and any other bill of this type that may come up in the future."

DISTRICT 16

(Brewster, Crane, Crockett, Culberson, Ector, El Paso, Glasscock, Hudspeth, Jeff Davis, Loving, Midland, Pecos, Presidio, Reagan, Reeves, Terrell, Upton, Ward, Winkler Counties)

Pat Hargrove, El Paso.
R. E. Thomason, El Paso (incumbent).

R. E. THOMASON,[1] El Paso: "I have your letter of the 21st instant. The status of the Wagner-Murray-Dingell Bill and my views concerning same are identical with those I gave when I wrote you on February 4, 1944, and which, as I remember, you published in your Journal.

". . . I have not had opportunity to study this measure as closely as I intend to do a little later. But wanted you to know that I have talked to Senator Connally about it and he said no hearings had been set by the Senate Committee and none scheduled. He expressed the opinion that the opponents of the measure have nothing to worry about at this time and in this belief I concur.

"Bills are sometimes so amended in Committee as to change their entire meaning and purpose, and it is therefore impossible to predict with certainty what will happen. If and when this bill ever comes to the House, it will have my exhaustive study and careful consideration. I will never vote for any plan to have the Federal Government take over the private practice of medicine. I may say that I have supported and will continue to support sound social security legislation, as I feel the features of this law that guarantee retirement annuities, old age pensions and unemployment insurance should be retained by all means."

DISTRICT 17

(Callahan, Comanche, Eastland, Erath, Fisher, Hamilton, Jones, Nolan, Palo Pinto, Shackelford, Stephens, Taylor Counties)

William W. Blanton, Albany.
Bryan Bradbury, Abilene.
Omar Burleson, Anson.
Mrs. Nina J. Headrick, Sweetwater.
Robert R. Herring, Breckenridge.
Gib Sandefer, Abilene.
Robert M. Wagstaff, Abilene.

WILLIAM W. BLANTON, Albany: "As you well know, there is a real and immediate danger that socialized medicine will be forced upon us in the guise of compulsory health insurance. If this happens, freedom will be destroyed in a profession where it

[1]Views of Texas Congressmen on 1945 Version of Wagner-Murray-Dingell Bill (Ed.), Texas State J. Med. 41:282-285 (Oct.) 1945.

[1]Views of Texas Congressmen on 1945 Version of Wagner-Murray-Dingell Bill (Ed.), Texas State J. Med. 41:282-285 (Oct.) 1945.

is essential, a great administrative cost will be added to the present cost of medical care, and ultimately doctors will be paid and empowered not according to their ability but according to their political pull, and patients will receive care according to their political pull . . . (Under socialized medicine) the medical profession would become another inefficient political agency, and the public as well as the doctors would pay the cost."

BRYAN BRADBURY, Abilene: "As a candidate for congress from the 17th Congressional District of Texas I am glad to go on record as to the following:

"I am opposed to the Wagner-Murray-Dingell bills and all similar proposed legislation.

"I am opposed to socialized and state medicine no matter under what name or banner it may parade."

OMAR BURLESON, Anson: "In response to your letter of June 20th, permit me to say simply that I am unalterably opposed to the Wagner-Murray-Dingell bills. I am constrained to go further and pledge myself as being opposed to any scheme which has as its ultimate, the continual leveling of society.

"If the principle of self-reliance is not a fallacy, then it must be a virtue. It must be a source of inexhaustible spiritual life and national advancement and any other idea sabotages our personal independence and destroys opportunities on which you and I are dependent for happiness."

MRS. NINA J. HEADRICK, Sweetwater: "I appreciate your request for my stand on the Wagner-Murray-Dingell bills, and am glad to make the following statement:

"As president of a woman's club of Sweetwater, some two years ago, my name headed the list of members of that club in a petition to our Texas Senators protesting the Wagner-Murray-Dingell bills. Personally, I made an intensive survey of these bills, pro and con, and from an impartial viewpoint; thus I came to the conclusion that such proposed legislation violates our Democratic way of life. Regimentation of the citizen's health and welfare would, in my opinion, seriously affect Americanized medicine and disrupt our present public health program."

ROBERT R. HERRING, Breckenridge: "I am opposed to the Wagner-Murray-Dingell bill (S. B. 1606). The regimentation of our medical services into agencies directed by politically appointed officials is a further threat to our way of life. Today, we in the United States enjoy the finest medical care in the world; a privilege made possible by the initiative and creative ability of our doctors working under a government which has promoted freedom of effort and of enterprise. This bill, if enacted, would tend to stifle that initiative and effort.

"We have available to the people of the United States today many forms of health and hospitalization insurance. We have various coöperative hospital movements which are furnishing our small communities with the ability to support a qualified doctor and hospital facilities under their own initiative. These are proving definite benefits to our public life, but they are not trends toward federally controlled socialized medicine, nor do they entail the tremendous tax burden which would be incurred by the enactment of this bill."

GIB SANDEFER, Abilene: "In answer to your recent letter I am pleased to state that while I am not thoroughly familiar with the provisions of the Wagner-Murray-Dingell bills, I am unalterably opposed to any regimentation or socialization of medicine."

ROBERT M. WAGSTAFF, Abilene: "With reference to your letter of June 20, I am opposed to socialized medicine and the Murray-Wagner-Dingell bills."

DISTRICT 18

(Armstrong, Briscoe, Carson, Castro, Childress, Collingsworth, Cottle, Dallam, Deaf Smith, Donley, Gray, Hall, Hansford, Hartley, Hemphill, Hutchison, Lipscomb, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher, Wheeler Counties)

The Hon. Eugene Worley, of Shamrock, incumbent, is without opposition. Mr. Worley is opposed to socialized medicine and the Wagner-Murray-Dingell bill.[1]

DISTRICT 19

(Andrews, Bailey, Borden, Cochran, Crosby, Dawson, Dickens, Floyd, Gaines, Garza, Hale, Haskell, Hockley, Howard, Kent, King, Lamb, Lubbock, Lynn, Martin, Mitchell, Scurry, Stonewall, Terry, Yoakum Counties)

Hope Halsey, Lubbock.
George Mahon, Colorado City (incumbent).

GEORGE MAHON,[2] Colorado City: "I am unalterably and unqualifiedly opposed to socialized medicine, have always been, and have frequently stated my position in personal conversations or in correspondence with doctors and other friends in my Congressional District. I feel confident that my views are well known among West Texas doctors and the people of my District."

DISTRICT 20

(Bexar County)

Jack Davis, San Antonio.
Paul Kilday, San Antonio (incumbent).

PAUL KILDAY,[1] San Antonio: "This will acknowledge the receipt of yours of September 21st, in which you request a statement on my position with reference to the socialized medicine provisions of the Wagner-Murray-Dingell bill.

"You can be sure that I am opposed to this provision, and that I shall actively oppose any proposal for the socialization of the medical profession."

DISTRICT 21

(Bandera, Brown, Coke, Coleman, Concho, Edwards, Gillespie, Irion, Kendall, Kerr, Kimble, Kinney, Lampasas, Llano, McCulloch, Mason, Menard, Mills, Real, Runnels, San Saba, Schleicher, Sterling, Sutton, Tom Green, Uvalde, Val Verde Counties)

The Hon. O. C. Fisher, San Angelo, incumbent, is without oppositiion. Mr. Fisher has recorded his opposition to the Wagner-Murray-Dingell bill and socialized mediciine.[1]

Each of the above races must be given the most careful consideration by Texas medicine, the friends of medicine and the public health. Apathy and indifference may readily prove disastrous to the finest system of medical care in the world.

It should be especially noted that in four Congressional districts—the Fifth, Sixth, Twelfth, and Seventeenth—former Congressmen, all of whom were definitely on record as opposing socialized medicine, are not running. It is heartening, indeed, to review the statements of those who are offering for these places, as well as all other places. Only three

[1]Views of Texas Congressmen on 1945 Version of Wagner-Murray-Dingell Bill (Ed.), Texas State J. Med. 41:282-285 (Oct.) 1945.

[2]Views of the Texas Congressmen on the 1945 Wagner-Murray-Dingell Bills (Ed.), Texas State J. Med. 41:391-392 (Dec.) 1945.

of the fifty-six candidates for Congressional seats who have furnished statements, indicate that they favor the socialization of medicine. The further observation that no statements were received from seventeen of the seventy-three candidates who were communicated with is a warning that dare not be ignored.

Medicine in Texas has a responsibility in the public interest in seeing that we send to Congress candidates who will preserve American medicine for the American public and not permit medicine to be the entering wedge for state socialism. Doctors of medicine have an obligation not applicable to any other group of citizens in supporting or opposing candidates on the basis of their attitude toward medicine and the public health. The medical profession because of its training and qualifications, must be the guardian of the public health of America.

The Position of Texas Gubernatorial Candidates on Socialized Medicine and the Wagner-Murray-Dingell Bill.—While the proponents of socialized medicine have so far not attempted to introduce legislation regimenting medicine and the public health in the Legislature of the State of Texas, sooner or later such an effort may be made. For that reason it was thought desirable that candidates for the offices of Governor and Lieutenant Governor in Texas should be requested to state their views on such matters for publication to the medical profession of Texas.

Accordingly under date of June 26, 1946, the following letter was addressed by the Secretary of the State Medical Association of Texas to each candidate for the offices of Governor and Lieutenant Governor of Texas to be voted on in the July 27 primary:

"The question of socialized medicine is of great interest to both the people and the physicians of Texas. The Wagner-Murray-Dingell bill, now before Congress, seeks to impose compulsory health insurance upon the people of the United States, regiment all doctors, and create a vast new tax burden.

"While, of course, this is a Federal matter, certain candidates for state office have voiced their approval of this legislation, which would affect every man, woman, and child in Texas. They have indicated that if elected they would use their influence in its support.

"For this reason, the doctors of Texas would appreciate learning how you stand in regard to the desirability of socialized medicine as embodied in the Wagner-Murray-Dingell bills.

"We would like to publish your statement in regard to this question in the next issue of the TEXAS STATE JOURNAL OF MEDICINE so that every doctor in Texas may be correctly informed.

"Enclosed please find reprint of a recent editorial from the TEXAS STATE JOURNAL OF MEDICINE which expresses the attitude of Texas doctors concerning the matter.

"We will appreciate a reply at your earliest convenience."

There follow herewith the names of each of the candidates for the offices of Governor and Lieutenant Governor of Texas, with the statement of each as received in response to the State Secretary's letter.

CANDIDATES FOR GOVERNOR

A. J. Burks, Odessa.
Beauford H. Jester, Corsicana.
Caso March, Waco.
Homer P. Rainey, Austin.
Jerry Sadler, Austin.
Grover Sellers, Austin.
John Lee Smith, Austin.
Reese Turner, Cameron.

A. J. BURKS, Odessa: "Answering your letter in regards to what I think of the question of socialized medicine and the Wagner-Murray-Dingell bill, I am bitterly opposed to this bill in its present form, as I do not think it right to make Guinea pigs out of children or family. The State and Federal Government should provide medicine and hospital care for those that are not financially able to pay, but as far as the State or Government putting a tax on each and everyone's salary or income whether he ever uses it or not is all wrong. When I wish or need a Doctor I am going to have my choice for my family.

"I hope it will be my privilege to put a stop to the nit wits in Washington telling us down in Texas what we can and what we cannot do. We should have some state rights left, but they are few and far between."

BEAUFORD H. JESTER, Corsicana: "I am glad to tell you that I am totally opposed to socialized medicine, either state or federal. Doctors should not be regimented either in Texas or in the nation.

"I want Texas to develop its own health program. I am opposed to the use of State funds in furtherance of any Federal program of socialized medicine and compulsory health insurance."

CASO MARCH, Waco: "I am against it (socialized medicine as embodied in the Wagner-Murray-Dingell bill) 100%. I have a medical program for Texas but it must be approved by the Texas Medical Association."

HOMER P. RAINEY, Austin: "I do not believe in socialized medicine. The right of a man to choose his own family doctor is almost as precious as his right to choose his own wife.

"But the provision of more hospitals, the training of more doctors, the financing of a great public health program—these things are not socialized medicine. The medical profession of Texas and the common citizenry alike recognize that we cannot allow men to suffer and die because we do not have facilities for their treatment. I shall seek the coöperation of the medical profession in Texas, so that we may provide for our people the finest public health system in America.

"Today we spend about eight cents a year—eight cents per year to protect the health of each of our citizens. That is a disgrace.

"I propose that we appropriate one dollar a year per person from state funds to operate this kind of public health program. With this money we can establish local health units, locally operated and locally maintained. We can put into effect a great program of sanitation and preventive medicine. We can set up a system of mobile medical and dental clinics to serve the needs of those who live in sparsely-settled rural areas. We can train more doctors and nurses."

JERRY SADLER, Austin: "Please let me state most emphatically that I am against socialized medicine in any form. I enclose a copy of my platform and call your attention to the '12th Plank' in this platform (which follows):

"Disease control. Special efforts will be made to reduce the widespread suffering and deaths of our children from polio, diphtheria, cancer and tuberculosis. The high rate of infant mortality must be decreased to guarantee the state a sturdy citizenship in the years to come. It is a sad commentary on our state government that only eight cents per person per year is paid out of state funds for public health. Almost that much is spent annually by the state on the preservation and care of wildlife. We should not spend more on our sick oysters than on our sick children."

GROVER SELLERS, Austin: "I publicly stated on June 14, 1946, and again on a state-wide radio broadcast on June 29, 1946, that I am opposed to socialized medicine.

"No doubt, it will also be of interest to the membership of your association to know the ways in which I firmly believe the public health program of Texas can be made of greater benefit to our people. In this respect, I favor:

"1. The construction by the State of two additional tuberculosis hospitals.

"2. An expansion of the State program of preventive medicine through public health units and through schools.

"3. An increase in the research facilities of the State, including a public research laboratory, to discover causes and prevention of contagious diseases.

"4. An adequate emergency fund for use by the State Health Department in time of epidemic.

"5. The establishment of adequate facilities for the care of the mentally sick."

JOHN LEE SMITH, Austin: "I am opposed to socialized medicine and actively fought Wagner-Murray-Dingell bills.

"President Truman's recent proposal for *compulsory* health insurance is meeting with widespread and increasing opposition.

"*While its purposes will be approved by many—the means of accomplishing these purposes create a greater danger to individual liberty and private enterprise than any possible good the proposal might bring.*"

While the medical profession of Texas will applaud the indication of Mr. Smith that he is opposed to the regimentation of medicine, they will also remember that as Lieutenant Governor of Texas and presiding officer of the Senate he broke the tie vote in that body in favor of passing a bill legalizing chiropractic for the first time in Texas. Fortunately this bill after being enacted into law was declared unconstitutional by the court of last resort in Texas.

CANDIDATES FOR LIEUTENANT GOVERNOR

Boyce House, Fort Worth.
Larry Mills, Dallas.
Drew Nichols, Austin.
Allan Shivers, Port Arthur.
Joed Winfree, Houston.

BOYCE HOUSE, Fort Worth: "Replying to your letter, may I quote from a radio speech which I will make Tuesday night, July 2, 1946:

" 'I am unalterably opposed to Communism, Socialism and to any other form of government except the American system, which means the greatest measure of individual freedom consistent with the general welfare. Being opposed to Reds and radicals, I am of course against socialized medicine.' "

ALLAN SHIVERS, Port Arthur: "I have your questionnaire with reference to my stand on socialized medicine. In my opening statement over a statewide radio broadcast in Port Arthur on June 27, I made the following statement: 'Allan Shivers has always opposed and will continue to oppose socialized medicine.'

"I would not want to see the legal profession to which I belong socialized and certainly my feelings about that would be the same for the medical profession. As you probably know I lean heavily upon the advice of my uncle Dr. J. F. Shivers of Woodville, Texas, for advice on medical legislation, and also my good friends in Port Arthur and Beaumont whom I have represented in the State Senate for the last 12 years."

JOED WINFREE, Houston: "It is hardly necessary for me to here tell you of the high regard in which I hold the medical profession; my record in the Legislature will, I feel, speak for me in that respect.

"As stated in your letter the bills of which you write are Federal matters. Nevertheless, I am not in favor of socialized medicine as embodied in these bills. Such bills would in my opinion, result in the lowering of the high standards of the profession, for, in time we would find ourselves with a system governed by political doctors. This is no reflection on our present-day doctors, but it is human nature to wish to rise in one's profession; in order to do this a doctor would soon find it necessary for him to turn his efforts to those of a political nature. Standards would fall, and the man who turned his efforts to politics to the neglect of the ideals of medical skill, would rise, while the man who devoted himself only to his practice would find himself in a mediocre position.

"The confidence of the patient in his doctor is only second to the skill of the physician and surgeon. Under a system of socialized medicine this personal angle is lost. I prefer not to have myself limited in the choice of my doctors. I do not wish to be compelled to pay a tax for services I neither want nor need. I prefer to be allowed to call the doctor of my own choice when I need him and where I need him."

Here, as in the statements of candidates from Texas to the U. S. Congress, published elsewhere in these columns, is the most heartening evidence that Texans seeking high offices of trust and responsibility, in almost 100 per cent of instances, have the same viewpoint as the medical profession toward such pernicious legislation as the Wagner-Murray-Dingell bill and other measures which would destroy all those features of our country that have made it the greatest nation on earth.

But here again we find that some candidates have failed to respond. In all fairness it should be noted that the letter of the State Secretary to candidates for the offices of Governor and Lieutenant Governor was sent June 26, candidates have been away on speaking tours, and some may not have had opportunity to furnish statements. And yet a sufficient number have done so to warrant some doubt regarding those who have not responded.

Without a dissenting statement favoring the socialization or regimentation of medicine from those offering for the highest offices in Texas, the medical profession will vote in accordance with their views on other

vital subjects as citizens, secure in the knowledge that if any of those quoted here are elected, our chief executives will look with disfavor on the regimentation of the medical profession and the public.

New Films for the Library.—The Motion Picture Lending Library of the Association has received the following additional films for relending. Appreciation is herewith expressed to the Westinghouse Electric and Manufacturing Co., the Winthrop Chemical Co., Becton, Dickinson & Co., Mead Johnson & Co., and the National Foundation for Infantile Paralysis for these worth-while contributions to the Film Library. A description of each film follows:

Accent on Use. 16 mm., sound, 1 reel, showing time, 20 minutes. (Available through the courtesy of the National Foundation for Infantile Paralysis.) The purpose of this picture is to make clear the part played by physical therapy in restoring patients to health and activity. It shows how the physical forces of nature—heat, cold, light, water, and electricity—have been utilized as one of the great adjuncts in the art of healing. Greater stress is laid on the treatment of infantile paralysis, but the value of this therapy in such diseases and injuries as arthritis, cerebral palsy, industrial accidents, and so forth, is emphasized. It will be found of interest to civic and parent-teacher groups, fraternal associations, high schools and colleges, industrial and other community organizations.

Continuous Caudal Analgesia. 16 mm., sound, showing time, 20 minutes. (Available through the courtesy of Becton, Dickinson & Co., Rutherford, N. J.) This picture was made by authorization of Dr. Thomas Parran, Surgeon General, U. S. Public Health Service, and bears the seal of approval of the American College of Surgeons. It is a short film, suitable for use at staff meetings or for showing to groups of doctors. It is suggested that, when discussion is to follow the showing, a doctor who has had experience in using this technic be present.

Regional Anesthesia. 16 mm., color, silent, showing time, 50 minutes. (Available through the courtesy of Winthrop Chemical Company, New York.) This film graphically presents the most important clinical phases of this subject. The fine points of technic are faithfully portrayed as well as the reaction of the patient to the anesthetic and to the operation. It presents actual operating room scenes, in which certain stages of the operations which follow each anesthetic procedure are depicted. Under abdominal regional block, supplemented by an intravenous anesthetic, a cholecystectomy is performed. Various methods of subarachnoid block are shown. The relatively complicated transsacral block anesthesia is given in detail. Under cervical plexus block, reduction of an ulnar fracture is portrayed. Finally, following ulnar and median nerve block, the replacement of a damaged digital flexor tendon with a graft is demonstrated step by step.

Forty Billion Enemies. 16 mm., sound, color, showing time, 25 minutes. (Available through the courtesy of Westinghouse Electric and Manufacturing Co., Mansfield, Ohio.) This film contains authentic information on maintenance and use of home refrigeration units and the storage of different foods. The causes of spoilage and the influence of temperature on germ growth are explained. There is no commercial message.

Cataract Surgery. 16 mm., black and white kodachrome, silent, showing time, 20 minutes. (Available through the courtesy of Dr. Ray K. Daily, Houston.) This film demonstrates the various techniques of cataract surgery.

Lease on Life. 16 mm., sound, 1 reel, showing time, 20 minutes. (Available through the courtesy of the U. S. Public Health Service.) This picture emphasizes the fact that health is a personal responsibility, and tells what to do about it. It is especially concerned with the early diagnosis of tuberculosis. It shows what is being done today in the many free clinics throughout the country, and the kind of information that is obtainable from the national and state health departments. It shows modern treatments in physical therapy at their latest and best, and stresses the importance of regular physical check-ups.

The Preparation of Human Serum. 16 mm., sound, 1 reel, showing time, 18 minutes. (Available through the courtesy of Mead Johnson & Company, Evansville, Ind.) The purpose of this picture is to acquaint the medical profession, and other interested groups, with the technique employed in the preparation of human serum.

Appraisal of the Newborn. 16 mm., sound, 1 reel, showing time, 20 minutes. (Available through the courtesy of Mead Johnson & Company, Evansville, Ind.) This picture shows the importance of family history, prenatal history, natal history, and postnatal history as valuable preventive measures, and for supplying information for future reference in helping make the day-old infant into a normal and healthy person.

Erythroblastic Anemia. 16 mm., sound, 1 reel, showing time, 18 minutes. (Available through the courtesy of Mead Johnson & Company, Evansville, Ind.) This is a lecture by Dr. Thomas B. Cooley. It is a comprehensive discourse, dealing with the diagnosis, pathology, prognosis, complications, and therapy of the disease.

The Library Building Fund Has Been Increased by the addition of contributions from the *Jasper-Newton Counties Medical Society,* as follows:

Dr. W. F. McCreight, Kirbyville	$ 5.00
Dr. James N. Seale, Jasper	5.00
Dr. J. J. McCrath, Jasper	5.00
Dr. A. J. Richardson, Jasper	5.00
Dr. A. J. Richardson, Jr., Jasper	5.00
Dr. S. G. Wilson, Pineland	5.00
Dr. G. Graham, Newton	5.00
Dr. G. M. Graham, Bessmay	5.00
Dr. W. R. Worthy, Call	5.00
Total	$45.00

While the new Committee on Library Endowment has not been set up for the current year, those in authority in the management of the Library are gratefully acknowledging this contribution, and will acknowledge all such contributions with equal appreciation.

There would seem to be no particular reason why this fund should not grow into considerable proportions. Indeed, there are doctors in Texas amply able to donate sufficient funds to make a library building immediately possible. There are doctors in Texas who have patients with money to give away, in large amounts, who need only to be told how much good, not altogether to the medical

profession, but through it to the public, could be done by the full development of our Library, and particularly its Package Service. Through this service any reputable physician in Texas may, almost immediately, secure the latest information on any medical subject upon which he needs prompt and competent advice. We will get results when and if we become enthusiastic in the matter.

Transactions of the Woman's Auxiliary Are Included in This Number of the Journal. Because of shortage of paper, all the Woman's Auxiliary notes, including the Transactions and list of members, had to be omitted from the June JOURNAL, where we customarily run them. The circumstances were quite embarrassing, but there was nothing we could do about it. There just was not enough paper to be had, and the Auxiliary material was the only block of approximately the right size for lifting. It seemed better to do that than to split the Transactions of either the State Medical Association or the Woman's Auxiliary. The importance of the Woman's Auxiliary to the work of the State Medical Association is particularly evident right now. We will do well to keep informed as to what that organization is doing, and how it is doing it. We will do better if we will help them, and, more to the point, let them help us.

TREATMENT OF EPILEPSY

A new drug, tridione, is destined to remove the blighting effect of epilepsy on the normal growth and education of many children, according to William G. Lennox, M. D., Boston.

Writing in the December 15 issue of *The Journal of the American Medical Association*, Dr. Lennox, who is associated with the Department of Diseases of the Nervous System, Harvard Medical School, and the Children's Hospital, said "Tridione, in my experience, has been the most dramatic in its effect of any form of therapy attempted." Out of 40 patients, 11 or 28 per cent were freed from epileptic seizures, 21 or 52 per cent experienced a 75 per cent or greater reduction in the number of seizures and 10 or 20 per cent were helped moderately. Treatment was discontinued in 2 cases. The author stated that "none failed to experience some amelioration of seizures."

There are three types of seizures which the author says "are most likely to benefit from this new medicine." The first, petit mal, is a transient lapse of consciousness, the second, myoclonic epilepsy, is a single quick contraction of muscles, and the third, akinetic epilepsy, is a sudden loss of postural control.

Since the effect of tridione treatment of epilepsy is still being investigated, it is not yet on the market. Some unpleasant side effects have been noted, namely a skin rash and an unusual sensitivity of the eyes to bright daylight. The author added, however, that pleasant reactions included an improvement in appetite and gain in weight by some patients. "In others the disappearance of clinical symptoms has been marked by an improvement in the school performance or in the deportment of the child."

SURGICAL TREATMENT OF CARCINOMA OF THE PANCREAS AND AMPULLA OF VATER

Analysis of 82 Cases

THOMAS G. ORR, M. D.*
KANSAS CITY, KANSAS

The feeling of hopelessness that formerly existed concerning the successful surgical treatment of carcinoma of the pancreas and ampulla of Vater has changed to some extent in recent years. Although the results of treatment are still far from satisfactory, a more hopeful outlook has been stimulated by the encouraging reports of radical removal of carcinoma involving the ampulla, head, body, and tail of the pancreas. The credit for stimulating general interest in surgery of carcinoma of the pancreas must be given to Whipple, Parsons, and Mullins,[29] who published their first report of successful pancreaticoduodenectomy in 1935. A review of the surgical literature since 1935 reveals a surprising number of surgeons who have become interested in the treatment of carcinoma of the pancreas and have recorded their technics and results of the radical operation.

TABLE 1.—*Diagnosis of Carcinoma of the Pancreas.* (Berk's Studies and Review).

INCIDENCE	
Head of pancreas (1,449 cases)	81.7%
Age (595 cases)	56.4
Males (1,120 cases)	71.3%
White race (273 cases)	71.4%
SYMPTOMS	
Duration of symptoms, onset to death (725 cases)	7.1 mo.
Pain as initial symptom (379 cases)	49.8%
Pain as chief complaint (173 cases)	48.5%
Pain at some time during disease (1,181 cases)	76.4%
Jaundice at some time during disease (1,361 cases)	68.8%
Painless jaundice on admission to hospital (68 cases)	17.6%
Painless jaundice during observation time (217 cases)	13.8%
Loss of weight, average 26.4 lb. (619 cases)	87.4%
Fatigue and weakness (186 cases)	51.1%
Anorexia (290 cases)	44.4%
Nausea and/or vomiting (759 cases)	42.3%
Constipation (573 cases)	38.7%
Diarrhea (679 cases)	10.8%
PHYSICAL FINDINGS	
Palpable liver (454 cases)	63.2%
Palpable gallbladder with jaundice (110 cases)	50.9%
Palpable pancreatic mass (707 cases)	37.3%
Ascites (737 cases)	23.7%
LABORATORY FINDINGS	
Glycosuria (622 cases)	9.4%
Hyperglycemia (252 cases)	19.4%
Impaired dextrose tolerance (163 cases)	20.8%
Precedent diabetes mellitus (275 cases)	6.9%
Anemia, hemoglobin average 75.7% (142 cases)	32.4%
Positive roentgenologic signs (367 cases)	37.0%
Hyperlipasemia	40.0-60.0%
Blood in stools (424 cases)	27.5%
Fatty stools (680 cases)	9.7%

SYMPTOMS AND DIAGNOSIS

Since successful surgical treatment of carcinoma of the pancreas must depend upon early diagnosis, a brief summary of the

*EDITOR'S NOTE.—Dr. Orr was an invited guest of the Section on Medicine, State Medical Association of Texas for the Annual Session, scheduled for Galveston, May 8-10, 1945, cancelled because of war conditions.

symptoms and signs of the disease are here outlined.

The excellent review of Berk[1] of the recorded signs and symptoms of carcinoma of the pancreas serves as a valuable guide in the diagnosis of this disease. Table 1, compiled from Berk's report, summarizes the incidence, symptoms, physical findings, and laboratory findings in carcinoma of the pancreas.

The belief so frequently expressed in the past that carcinoma of the head of the pancreas is usually associated with painless jaundice must be modified, since pain has been found to be an outstanding symptom in carcinoma of the ampulla and head of the pancreas in over 75 per cent of the cases. Moersch and Comfort[20] made the statement that "carcinoma of the pancreas should be suspected in any individual of middle age who complains of a deep-boring upper abdominal pain of short duration, relieved by bending forward, and associated with a rapid loss of weight." In a study of 16 cases of carcinoma of the body and tail of the pancreas Ransom[23] stated that "the symptomatology is characterized by severe pain, frequently occurring in crises, rapid and extreme emaciation and complete absence of jaundice." The insidious onset of weakness, loss of appetite, aversion to greasy foods, gas in the stomach, epigastric uneasiness or discomfort suggest the early diagnosis of carcinoma of the pancreas.

The roentgen-ray may be an aid in diagnosis by showing a deformity of the duodenum or displacement of the stomach. Displacement of the stomach may be detected in carcinoma of the body. Bulging of the posterior gastric wall may be seen with the gastroscope (Moersch and Comfort[20]).

Diagnosis at the operating table may present some difficulties. Carcinoma must be differentiated from chronic pancreatitis, hepatitis, stone impacted in the ampulla, stricture of the common duct, carcinoma of the gallbladder, carcinoma of the liver—primary and secondary, primary carcinoma of the duodenum, extrabiliary lymph nodes, and benign tumor obstructing the papilla of Vater. To establish a positive diagnosis, a duodenotomy may be necessary for exploration and biopsy of the papilla.

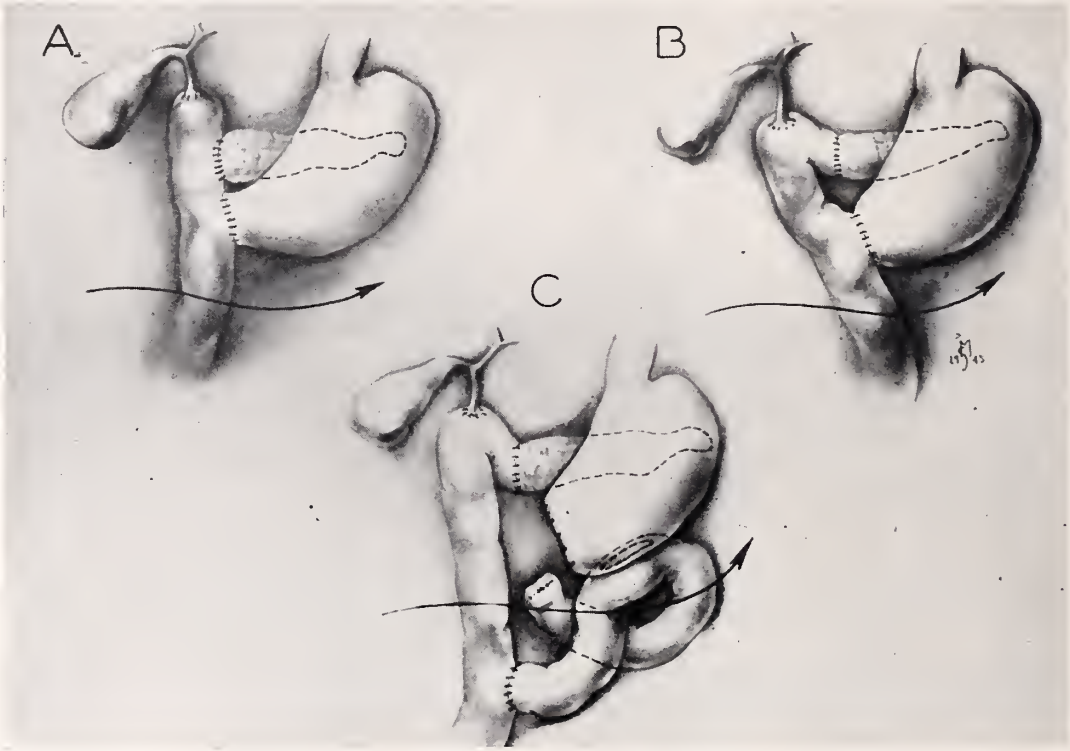

FIG. 1. Completed operations showing three methods of pancreaticoduodenectomy. A, Whipple technic; B, Child technic; C, technic used by the author in a two-stage operation.

TREATMENT OF CARCINOMA OF THE BODY AND TAIL

Brunschwig[2] indicated that Oberling and Guerin up to 1930 had recorded 11 cases of malignant tumors of the body and tail of the pancreas in which operation had been done successfully. This group included both carcinomas and sarcomas. In some cases the

descriptions were obscure and the diagnosis doubtful. Table 2 summarizes a series of cases reported since 1930 which show results of partial and complete pancreatectomy for carcinoma of the body and tail of the pancreas.

These case reports indicate that carcinomas of the body and tail of the pancreas are not entirely hopeless when discovered early and adequately removed.

PALLIATIVE OPERATION

The average length of life following 186 recorded palliative operations by several authors[9, 12, 15, 16, 17, 25, 30] was 9.2 months.

All patients with suspected carcinoma of the pancreas should be explored. When jaundice exists and radical excision of the carcinoma is not possible, an anastomosis between the gallbladder or common duct and the gastro-intestinal tract is indicated. Patients are usually very grateful for this type of operation, which relieves them of the torment of intense itching. In many cases with metastases in the liver appetite and digestion will improve after a palliative operation, making life worth living for several months. Palliative operations are also indicated when the carcinoma invades the pyloric region or duodenum and causes obstruction.

LOCAL EXCISION OF CARCINOMA OF THE AMPULLARY REGION

In 1941 Hunt[14] reviewed 56 recorded cases of transduodenal excision, excision of tumor with section of the duodenum, and retroduodenal excision of carcinoma of the ampulla or adjacent structures. Twenty-four patients reported dead had lived an average of 17.4 months and 32 patients reported alive had lived an average of 32.5 months. The operative mortality in a series of 109 cases was 31.1 per cent. Gray and Sharpe[12] added 5 cases of transduoenal excision in 1943 with an average length of life after operation of 22.8 months. The operative mortality rate of these authors in 8 cases was 37.5 per cent.

These records show an average length of life following the local operation greater than that obtained by the more radical pancreaticoduodenectomy. The reason for such results is without doubt the relatively early excision of small local growths.

TABLE 2.—*Partial or Complete Pancreatectomy for Carcinoma of Body and Tail of Pancreas.*

Author	Year	Age	Sex	Location of Tumor	Type of Operation	Pathologic Observations	Results
Gordon-Taylor[11]	'34	54	M	Body	Subtotal pancreatectomy	Columnar cell carcinoma	Alive 7 yr. after operation
Doberer[10]	'38	47	M	Body, tail	Partial pancreatectomy, splenectomy	Carcinoma, metastases found at autopsy	Died on 5th postoperative day
		62	F	Body	Local excision	Adenocarcinoma	Alive 2.5 yr. later
Milhiet, Dormay, & Feyel[19]	'40	39	F	Body	Subtotal pancreatectomy	Carcinoma, metastases not recorded	Lived 2 mo.
Harvey & Oughterson[13]	'42	48	M	Body	Splenectomy, subtotal resection of pancreas	Adenocarcinoma, metastases to lymph nodes	Lived 5 mo., died with metastases, no autopsy
Rockey[24]	'43	51	M	Body	Partial gastrectomy, total pancreatectomy, total duodenectomy	Carcinoma, no metastases found at operation or autopsy	Died on 15th postoperative day
Brunschwig[3]	'44	32	M	Body	Subtotal pancreatectomy, excision of sections of stomach and jejunum	Carcinoma, metastases found at final operation	Lived 3 yr., 11 mo.
		73	F	Body	Subtotal pancreatectomy, splenectomy	Carcinoma, metastases found at operation	Died 3rd postoperative day
		66	M	Body	Subtotal pancreatectomy, splenectomy	Carcinoma, metastases found at operation	Lived 5 wk.
		55	F	Body	Partial gastrectomy, pancreaticoduodenectomy	Carcinoma, no metastases noted	Died 10th postoperative day
		49	M	Body	Partial pancreatectomy, splenectomy, adrenalectomy	Carcinoma, metastases found at autopsy	Lived 5.5 wk.
		55	F	Body	Subtotal gastrectomy, splenectomy, partial pancreatectomy, excision falciform ligament and umbilicus	Carcinoma, metastases found at operation	Alive 3 mo. after operation
		67	M	Entire pancreas	Total pancreatectomy, splenectomy	Carcinoma, metastases found at operation	Died 3rd postoperative day
		29	M	Entire pancreas	Total pancreatectomy, splenectomy	Carcinoma, metastases found at autopsy	Died 9th postoperative day
Brunschwig, Ricketts, & Bigelow[6]	'45	53	M	Body, tail	Total pancreatectomy, total gastrectomy, splenectomy, total duodenectomy, adrenalectomy, omentectomy	Carcinoma, metastases found at operation	Lived 3.5 mo.
McClure[18]	'44	46	M	Body	Total pancreatectomy, duodenectomy, splenectomy	Carcinoma, no statement about metastases	Alive when reported 3.5 mo. after operation

PANCREATICODUODENECTOMY

There have been more than 100 cases of pancreaticoduodenectomy recorded in the American literature, and reports are now appearing very frequently. Final results have not yet been summarized and the value of the operation cannot be estimated at this time. In a series of 23 cases reported by Whipple and others[29] in which the final results were known, patients lived from 5 to 21.7 months after operation. In a similar series of 33 cases in which patients were still living the length of life recorded was 9.3 to 15 months.

The one-stage operation is the procedure of choice. There are patients whose general conditions will not tolerate one-stage operations and two-stage operations must be used for the sake of safety. In a series of 57 cases[22] with two-stage operations the average operative mortality was 28 per cent and in 46 cases with one-stage operations the mortality rate was 32.6 per cent.

TABLE 3.—*Cases of Carcinoma of the Pancreas, University of Kansas Hospitals, June, 1920, to December 31, 1945.**

Total	82
Involving head or ampulla	62
Involving body or tail	20
Palliative or exploratory operations	49
Pancreaticoduodenectomies	9
Clinical diagnosis only	12
Autopsy diagnosis only	12
Known deaths	69
Untraced	13

*Fifty-two of these cases have been studied previously with reference to fatty infiltration of the liver.[26]

There is both experimental[21] and clinical evidence[5] to show that there is frequently a disturbance of fat metabolism when the pancreatic duct is completely obstructed or when the head of the pancreas is removed without restoration of the pancreatic secretion by anastomosis between the severed end of the pancreas and the intestine. In the cases reported by Whipple, Parsons, and Mullins[28] the severed end of the pancreas was closed. Their studies showed that 80 to 90 per cent of fat was absorbed in the absence of the external pancreatic secretion. Complete obstruction of the pancreatic ducts causes atrophy and fibrosis of the acinar structure of the pancreas without apparent effect upon the islands of Langerhans.

The question of the advisability of anastomosis between the pancreatic stump and intestine is still undecided. Brunschwig has expressed some doubt about the external excretory function of the pancreas after implantation of the pancreatic stump into the intestine. Exclusion of pancreatic secretion by closing the severed end of the pancreas has been shown to be compatible with life for at least three years. Brunschwig[4] ligated the pancreatic duct of a monkey which lived in apparent good health for four years. Reasoning from the physiologic standpoint, it is desirable to anastomose the severed stump of the pancreas to the intestine to restore its external secretion. By making such an anastomosis it is probable that the frequency of pancreatic fistulas may be reduced to a minimum.

TABLE 4.—*Palliative and Exploratory Operations, University of Kansas Hospitals, June, 1920, to December 31, 1945.*

Cholecystogastrostomy	13
Cholecystoduodenostomy	3
Cholecystojejunostomy	2
Cholecystostomy	2
Choledochoduodenostomy	3
Gastroenterostomy for obstruction	5
Duodenojejunostomy for obstruction	2
Exploratory operations	19
Total	49
Mortality of palliative operation	43.3%
Mortality of exploratory operation	52.6%

Almost every surgeon who has reported a case of pancreaticoduodenectomy has described some alteration in the technic. These many different procedures have been somewhat confusing but general principles have now been established which should be followed when possible. The technics suggested by Whipple,[27] Hunt,[14] Child,[7] and Cole and Reynolds[8] illustrates the principle that anastomoses between the gall tract and intestine and between the pancreas and intestine should be proximal to the anastomosis between the stomach and intestine to minimize ascending infection in the gall tract and pancreas from the content of the gastro-intestinal tract.

The plan of the operation should include: (1) anastomosis of the common bile duct instead of the gallbladder to the intestine to insure adequate flow of bile and to minimize the danger of biliary fistula; (2) anastomosis of the common duct and pancreas to the intestine proximal to the gastro-intestinal anastomosis to prevent ascending infections in the liver and pancreas by shunting the intestinal stream so that it will not flow past the anastomoses (Fig. 1); and (3) to reduce

TABLE 5.—*Pancreaticoduodenectomies for Carcinoma of the Ampulla and Head of the Pancreas, University of Kansas Hospital, 1940-1945.*

Year	Patient	Age	Sex	1 or 2-stage Operation	Length of Life after Operation
1940	C. T.	47	M	2	Lived 33 mo.
1940	M. B.	67	F	2	Lived 23 mo.
1941	G. P.	65	F	2	Lived 20 mo.
1941	A. B.	59	M	1	Lived 34 mo.
1942	A. M.	72	F	2	Alive 24 mo. (Dec. 31, '45)
1943	M. S.	56	F	1	Lived 9 mo.
1944	I. F.	54	M	1	Lived 12 mo.
1945	H. B.	68	M	2	Postoperative death
1945	O. B.	39	M	2	Postoperative death

NOTE: The first 7 cases have been reported previously.[22]

the number of anastomoses to a minimum to conserve time of operation. If a two-stage operation is necessary it may be advisable to use the gallbladder for anastomosis to the stomach or duodenum and plan to detach such anastomosis and substitute a choledochoenterostomy at the second stage of the operation. It must be recognized that in the occasional case an anastomosis between the gallbladder and the stomach or intestine may not result in an adequate flow of bile because of obstruction or partial obstruction of the cystic duct.

REVIEW OF AUTHOR'S CASES

The records of the University of Kansas Hospitals from June, 1920, to December 31, 1945, show a total of 82 cases diagnosed carcinoma of the pancreas or ampulla of Vater (table 3). Of this number 59 have been admitted to the hospital in the last ten years. There were 30 palliative and 19 exploratory operations (table 4).

Nine pancreaticoduodenectomies have been done since 1940 with two postoperative deaths (table 5). The operative mortality was 22.2 per cent. In the two postoperative deaths the carcinoma involved the mesenteric vessels and was too extensive to be completely removed. A pancreaticoenterostomy was made in 6 cases. One patient is still alive twenty-four months after the second stage of the operation but has an enlarged liver which is apparently due to metastases. Seven of the patients died after leaving the hospital and autopsies were not obtained except in 1 case. Extensive metastases were found in this case and clinical examination revealed what was considered metastases in all cases.

Two pancreatic fistulas developed in this series, one of which persisted for several weeks and the other less than two weeks. Ascites developed in 1 case after the first stage of the operation and the second stage was delayed for three months. Hypoproteinemia was a complicating factor in most of the cases. The cause of death in 1 case was peritonitis. The second postoperative death occurred two weeks after the patient was discharged from the hospital and the immediate cause of death is not known.

Sixty-nine of the series of 82 patients are known to be dead and 13 have been untraced. Thirty-nine patients died in the hospital.

CONCLUSIONS

A study of the results of the radical operation for carcinoma of the body and head of the pancreas or the ampulla offers some hope that a small percentage of cures may be obtained if a diagnosis is made early.

Local excisions of carcinoma involving the ampulla and papilla of Vater have produced comparatively good results, but local lesions are relatively uncommon as compared to the usual more extensive growths found at operation.

Greater length of life has resulted with radical pancreaticoduodenectomy than with any type of palliative operation.

A further careful follow-up study is necessary to determine the final results with the average length of life following pancreaticoduodenectomy.

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BENADRYL, ITS THERAPEUTIC VALUE IN ALLERGY

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Each year in the field of allergy it has been necessary to discard that "heralded drug" which received much acclaim from the various pharmaceutical houses and the lay press.

Within the past six years at least six such drugs have come and gone. First came potassium chloride as the "wonder drug," but after two years' observation it was dropped. Then "torentil" (histaminase) was the sure cure, but critical clinical review has proven it absolutely worthless. Then came "B. Coli-Metabolin," offered in 1941 by Dr. Ernest Elsbach, which survived for only one season. Later the vitamins were popularized; particularly vitamin C was given the prima donna role by Dr. Harry N. Holmes. Critical study by Feinberg has shown that the allergic patient does not present a vitamin C deficiency and is definitely not improved by such therapy. Then came the "sure cure" for allergic syndromes—ethylene disulfonate, by Spicer of California. On investigation, it has been a true failure and is now resting in the limbo of forgotten therapeutic agents. Within the past two years "hapamine" (despeciated horse serum) has had its advocates, but again it has not been the answer for the allergic patient. In fact, it has been responsible for some very severe reactions and now is on the way out.

The latest arrival and promised new hope for the allergic—called by some allergy's foe—is benadryl.

DESCRIPTION AND PROPERTIES

Benadryl is a new chemical compound synthesized by Rieveschl and Huber and distributed by the Parke, Davis & Company. Its action is anti-histamine-like and definitely antagonizes the effects of histamine on the smooth muscle of the bronchioles and intestines of the guinea pig.

The chemical name of this compound is beta-dimethylaminoethyl benzhydryl ether hydrochloride, and its structural formula is as follows:

Beta-dimethylaminoethyl benzhydryl ether hydrochloride is a white crystalline powder, soluble in water and alcohol. The solution may possibly have a slight opalescence. It is stable under ordinary conditions of temperature and atmosphere.

Its chief pharmacologic actions are three when applied on animals.[6, 7, 9, 10, 11] It alleviates (1) the bronchial constriction caused by histamine in anaphylactic shock, (2) the vasodepressor effects of histamine, and (3) the spasm of smooth muscle.

In conditions where bronchial constriction was induced by histamine shock, it has been repeatedly demonstrated that the mortality rate from histamine shock approaches 100 per cent in any untreated controlled group of guinea pigs. To this same group the mortality rate will be reduced to 47 per cent with adequate aminophyllin, and to zero when benadryl is given in adequate amounts intraperitoneally.

The antispasmodic effect was noted in in vitro experiments on guinea pig ileal muscle. Using papaverine hydrochloride as an activity index for 1.0, it was discovered that the ratio of benadryl relative to antagonism of histamine was 650 times more effective, 50 times more effective than acetylcholine, and 1.3 times as effective in antagonizing the contractile effects of barium chloride.

Toxicologic studies[6, 7, 9, 10, 11, 14] were made on albino mice and rats, rabbits, and dogs. Lethal doses showed that violent excitement, convulsions, and respiratory failure preceded death. With nonlethal toxic doses in dogs, violent ataxia and excitement occurred and visual and mental acuity apparently were unchanged. When rather massive nontoxic doses were given to dogs over a long period, there were no changes in the erythrocyte and leukocyte counts, in the hemoglobin or differential blood counts, or in nonprotein nitrogen levels. Complete histopathologic studies which were performed showed no evidence of acute or chronic degenerative changes. Marked congestion was present in the choroid plexuses for reasons yet unknown.

DOSAGE

Benadryl is supplied in three dosage forms: as Kapseals (hermetically sealed capsules) each containing 50 mg. benadryl;

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as an elixir, each 4 cc. (one teaspoonful) containing 10 mg. benadryl; and also in rubber capped vials containing 10 mg. per cc.

Adults.—The average adult may take one Kapseal every four hours. The effect appears in ten to twenty minutes and frequently lasts five to eight hours. When given intravenously benadryl is given in the amount of 60 mg. of benadryl per 100 cc. of normal saline solution and should take at least ten minutes for administration. When given parenterally it gives effect within three to ten minutes, and the effect lasts four to five hours. Some have also given benadryl intramuscularly but because it is painful and moderately irritating, I advise against this procedure.

Children.—Logan[8] has advised 2 mg. per pound of body weight, this quantity being best divided into from two to four doses. I have frequently given 5 year olds a 50 mg. Kapseal per dose. When benadryl is given by elixir, anesthesia of the tongue, momentary in type, has been noted.

UNTOWARD EFFECTS

Sleepiness.—About 1 out of 5 patients experiences a sensation of sleepiness or drowsiness. This effect has proven serious on a few occasions. It therefore behooves the physician always to make this warning when the drug is prescribed. In some patients it may be overcome by giving black coffee, caffeine, benzedrine, or ephedrine. In others the dosage may have to be reduced.

I know of a physician in Philadelphia who, after taking 3 capsules, became so drowsy he failed to heed three red traffic signals while driving his car and was arrested for being intoxicated. This later proved to be a "benadryl jag." Another man in Minneapolis, after taking benadryl, collided with a telephone pole, causing major damage to his automobile and necessitating several stitches about the face. One of my colleagues was advised to take 6 capsules daily because of his vasomotor rhinitis. He became so drowsy that a patient had to shake him awake during a conference. Benadryl reduced to 4 capsules a day cleared his vasomotor rhinitis and he had no more "sleepy conferences." Another patient, a lawyer, became so sleepy after 1 capsule while attending a board of director's meeting that the session had to be postponed to a later date. Another patient experienced syncopy after 1 capsule. However, this drowsy factor is a boon for the hay fever patient who sleeps poorly at night, providing the sleepy factor affects him.

Other side effects.—In addition to sleepiness or drowsiness, the following side effects have been noted: dizziness, atropine-like effect (dry mouth and some disturbance in vision), epigastric distress with an occasional tendency to vomit, nervousness (jitteriness), urinary frequency, and mild interference in coördination. There is no evidence of cumulative action, and so far there is no contraindication during pregnancy. In fact, benadryl has a definite antispasmodic action on the nonpregnant uterus. So far there has been no report giving evidence that blood counts or blood end products have been affected.

Special warning.—Care should be taken in administering benadryl to any patient who has received a hypnotic or sedative such as barbiturates or opium derivatives, and also in treating the "aspirin (acetylsalicylic acid) patient" since benadryl contains a coal tar radical.

THERAPEUTIC USES OF BENADRYL

Urticaria.—Patients with urticaria are a challenge and an etiological enigma. It is only in the occasional patient that an offender appears because this condition is not on the reagin mechanism and as a result usually gives negative skin tests. In all such cases one should always first consider drugs, foods, infection, and psychological factors. In a few, such rarities as leukemia, Hodgkin's disease, and malaria may be the explanation. In quizzing for drugs the physician should not ask the patient, "Do you take any drugs?" He should proceed by somatic exclusion, starting from the head and going down, that is, asking what the patient uses for headaches, mouth wash, insomnia, constipation, vaginal douches, rectal suppositories, and last, but not least, nose drops.

Of all the allergic syndromes in which I have tried benadryl its best effectiveness is in the urticarial group. Curtis and Owen[2] first reported its use in 18 cases—11 experienced prompt relief, 3 were definitely improved, while 4 failed to respond. O'Leary and Faber[13] reported 35 chronic cases where the average age of the patient was 42 years and duration of the urticaria 4 years (shortest 4 months, longest 30 years). Of the 35 patients 25 became well, but all had to remain on benadryl. Todd[16] reported 47 out of 52 patients were given complete relief, 4 partially, and 1 incompletely. Shaffer[15] also reported a favorable study of chronic urticaria responding to benadryl.

I have given benadryl to 26 patients with chronic urticaria and it has controlled all symptoms in 19 of them. A representative case is that of Mrs. L. O. M., aged 59 years, who, since 1943 had hives daily for three years. She was studied for infection, her

teeth were extracted, histamine was given subcutaneously, vitamin K was tried, she practically starved for days, hapamine was also given—but all to no avail. For two days she was given benadryl every four hours, and now 2 capsules daily afford 100 per cent relief.

Angioneurotic Edema.—The Parke, Davis & Company group[14] reported improvement of 83.3 per cent in 30 cases of angioneurotic edema. In my 4 cases it was 100 per cent effective in 3, but of no relief in 1.

Angioneurotic Edema (Horse Serum Sensitive Case).*—Baby C. J., aged 2 years, because of an accident was given 1,500 units of tetanus antitoxin, subcutaneously, on March 11, 1946. Forty-eight hours later he had a violent urticaria and three days later his edema was so massive and the respiratory difficulty on March 18 (six days following the original injection) so critical that a bad prognosis had been given the parents. All emergency measures had been tried. Epinephrine in oil and aqueous solution, plus glucose intravenously had been given. At 5 p. m., March 18, when his condition appeared hopeless, 100 mg. of benadryl was given by mouth, followed by 50 mg. every four hours for four doses, then 50 mg. every six hours for twenty-four hours. On March 21 he was discharged completely well. This case indicates that in an emergency children can be given more benadryl than was originally proposed and that benadryl is of great aid in serum cases.

Hay Fever.—Parke, Davis investigators[14] reported 404 cases with 82.4 per cent improvement. My own results in 83 benadryl cases was about 60 per cent. Yet Derbes[3] of New Orleans, reported about 70 per cent of his group were definitely improved. Efron[4] of New Orleans, reported 65 per cent improvement in his ragweed group. I had 3 patients who reported in mid-ragweed season, and with benadryl only they were amazingly benefited. The best cases for improvement were those which gave a large whealing on testing.

Hay Fever X[17].—This is a particular type of hay fever encountered in the south. Patients with this hay fever usually have their symptoms in May and persist throughout the summer, gradually tapering off toward the end of September or the beginning of October. There is diurnal variation in the symptoms; most patients suffer worse at night and early in the morning, often being nearly or quite free in the afternoon.

Investigation with all known pollens and fungi and treatment with them fails to give relief to these patients. Patients present this group of symptoms in various parts of the country but are in abundance in the coastal area roughly including the southern part of South Carolina, southern two-thirds of Georgia and Alabama, northern Florida, western tip of Tennessee, Mississippi, Louisiana, and southeastern Texas.

My attention was first brought to these patients by Dr. Clarence K. Weil, of Alabama, in the spring of 1937. This syndrome is now under active investigation by Dr. B. G. Efron[4] of New Orleans, whose findings parallel Weil's. Studies so far indicate this syndrome may or may not be due to fungi. Treatment with all known fungi has not benefited this group of hay fever victims. Clinically these patients are classified as belonging to summer hay fever of unknown origin or "X hay fever." Of this group benadryl helped 30 per cent.

Vasomotor Rhinitis.—Parke, Davis investigators[14] reported 274 cases of vasomotor rhinitis with 74.4 per cent improvement. My results were less than 20 per cent. Here again I have seen a few patients who were definitely benefited by 3 capsules daily.

Asthma, Bronchial.—Treatment of bronchial asthma has been a true disappointment; in fact, benadryl has been of little help in asthma. I have had less than 10 per cent improvement here; yet Parke, Davis investigators[14] reporting 343 cases, claimed 63.5 per cent improvement but candidly admitted many were poorly classified.

Migraine. — The same Parke, Davis group[14] reported 62 cases of migraine with 67.7 per cent improvement. I gave 3 true classical migraine patients benadryl with no improvement in any. They[14] also reported benefit in 4 cases of histaminic cephalgia (Horton's syndrome). In my 1 case the result was zero.

Drug Allergy—"Aspirin (Acetylsalicylic Acid) Sensitive Cases."—Mr. T. W., aged 41 years, had been an asthmatic-hay fever problem for more than twenty years. He was authentically known to be allergic to aspirin. Once by mistake he was given one "Arlcap capsule, gr. 5" which contained 2 gr. of acetylsalicylic acid. This immediately provoked a violent asthmatic attack; hospitalization with emergency measures was needed for the next two days. Four years later while visiting in Amarillo, he experienced a terrific headache. He asked a druggist for a headache preparation not containing "aspirin" and the clerk advised "Alka Seltzer." This precipitated a violent attack; he was hospitalized for ten days and needed oxygen constantly. Knowing this case to be a true allergic problem to coal tar drugs, I purposely gave him a 50 mg. capsule of benadryl at 10 a. m. when he was perfectly free of asthma. Within ten minutes he was troubled by cough; within twenty minutes the cough was severe and his forehead was beaded with perspiration; then came violent asthma which required emergency administration of epinephrine, aqueous, 4 mg.; epinephrine, 1 cc. in sesame oil, subcutaneously, and then aminophyllin, 7.5 gr. in the vein. It took about two hours before the patient was comfortable. This is my second aspirin-sensitive patient whose asthmatic attack was provoked by taking benadryl; therefore, caution should be taken to ask all benadryl users if they are aspirin or coal tar drug sensitive.

*Case in consultation with Dr. Harriet Boardman, Houston.

Penicillin Reactions.—The Parke, Davis group[14] reported 53 cases with 98.1 per cent improvement in penicillin allergies. I have observed 6 cases of severe urticaria in children following the use of penicillin nose drops. All were controlled within a few days by benadryl. It also aided in the control of urticaria in 11 adults who had received penicillin for infection.

Vitamin B (Thiamin Chloride) Reactions.—On four occasions I have had very severe reactions in patients following the giving of vitamin B. On one occasion the reaction followed the eighth subcutaneous injection of 100 mg. Immediately at all the other sites there was an Arthus-like reaction, generalized urticaria, and shock-like symptoms. The entire clinical picture was immediately controlled with benadryl and epinephrine.

Dermatological Conditions.—Benadryl is frequently effective in dermatological problems where there is an associated edema and much pruritis.

Eczema.—In juvenile eczema benadryl has been a great help in allaying pruritis when given in the amount of 2 mg. per pound of body weight. In the older patient having neurodermatitis it has definitely decreased itching. The Parke, Davis group[14] reported 72.7 per cent improvement in 44 cases. In the eczema group I have observed relief in the paroxysms of pruritis which was striking in 6 cases.

Contact Dermatitis.—Benadryl has definitely decreased the itching in 4 cases of grass contact dermatitis in children, and in 1 case of poison ivy it was a distinct help.

Dermographia.—The Parke, Davis report[14] stated that of 10 cases of dermographia, 70 per cent showed improvement. I had 1 case which presented dramatic relief after two weeks treatment. An excellent study of this syndrome has been reported by Feinberg.[5]

Food Allergy.—The Parke, Davis group[14] reported 90.9 per cent improvement in 22 cases of food allergy. My results have been very unsatisfactory in food allergy. In no case could an offending food be left in the diet and benadryl be given with clinical improvement except where the child, restless because of his food, would rest better at night because of the drowsiness provoked by benadryl.

Dysmenorrhea.—The Parke, Davis group[14] reported 91.5 per cent results in 26 cases. This phase I have not evaluated.

Insect Allergy.—Benadryl was 100 per cent effective in 1 case of yellow jacket sting. The patient had previously experienced some angioneurotic edema and carried benadryl as a prophylactic.

Meniere's Syndrome.—Here the Parke, Davis group[14] reported good improvement in 3 out of 6 cases. I have tried it in only 1 case and it gave relief as long as the drug was used.

Miscellaneous Uses.—It has been shown experimentally[2, 6-11, 13-16] that benadryl appreciably decreases the secretion of gastric hydrochloric acid. This needs further evaluation in the possible treatment of peptic ulcer. Benadryl is also of proven value in cases of cold allergy.[1, 3-5, 11, 12, 17] It has also been shown to relieve the vasospasm of the hands that occurs in aerosclerosis,[1] which is a form of regional soleroderma with Reynaud's component.

CONCLUSION

Benadryl has a true place in allergy. Its best effect is in cases of chronic urticaria. It is an excellent aid to the ragweed sufferers with results of improvement between 60 and 70 per cent. It has little value in helping the asthma patient. All patients should be warned that benadryl makes about one out of five very sleepy, although this effect may be minimized by caffeine or benzedrine. Benadryl should be used carefully for any patient who is aspirin (acetylsalicylic acid) sensitive. To those patients who have marked pruritis in neurodermatitis, it is a great aid. It may have a place in certain gastro-intestinal cases since it definitely causes a reduction of gastric acidity.

When insulin was given to the medical profession it did not permit the diabetic patient to disregard his diet instructions, and their diabetic principles. Neither does the use of benadryl exclude good allergic investigation, dermatological care, or internal medical study. It is to date only an adjunct in the management of allergic cases.

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ABSTRACT OF DISCUSSION

Dr. A. H. Braden, Houston: Dr. Bowen has given us an excellent evaluation of benadryl. He has stated both its efficacy and its shortcomings fairly. It is true that as each new drug is presented to the profession, its advent is always heralded with statements that are too optimistic. This is especially true in the field of allergy. The very nature of diseases of allergy lends itself especially for all varieties of exploitation. Since no one knows why the allergic state exists in certain persons, these persons are an open sesame for all sorts of "cures."

I have tried my share of these new drugs, and I am sorry to say that I not only have been disappointed, but in one particular instance I received a shock that was almost equal to the constitutional reaction that I produced in a patient. This drug was hapamine.

So naturally, when benadryl appeared on the scene, I viewed it with a great deal of apprehension. First through the courtesy of Dr. Bowen, and later through the courtesy of Parke, Davis & Co., I used several thousand capsules before it was released to the drug stores. I have now used it in something over a hundred patients. Approximately 50 per cent of these cases consisted of urticaria or some form of dermatoses, while the remainder consisted of hay fever, so-called vasomotor rhinitis, asthma, and migraine.

On the whole, my experience with the drug parallels Dr. Bowen's experience rather closely. The one exception that I would make is that it has not helped 60 per cent of my hay fever patients. Since the number of hay fever patients that received the drug was small, my experience would have little value from a statistical viewpoint. By far the best results were obtained in urticaria.

In conclusion, I want to reiterate Dr. Bowen's statement as regards side effects. Benadryl should be used with caution, and patients should be told that it may produce sleepiness, dryness of the throat, and sometimes nausea and nervousness.

Finally it must be remembered that benadryl very definitely is not a curative drug. If it helps at all, it only relieves symptoms, and patients will still have to be thoroughly investigated as to the cause of their allergy, no matter what it be.

Dr. George J. Seibold, Houston: Benadryl has offered more relief to the allergic patient than any single therapeutic agent or combination of agents since the clinical application of epinephrine (adrenalin), which came into use in 1901. Enthusiasm must be tempered, however, by the practice of intelligent clinical medicine—and the use of the drug never obviates careful scientific allergic supervision.

Dr. Bowen has pointed out the stormy and short-lived histories of a group of therapeutic agents that were ushered in to the public by way of the lay press and pharmaceutical houses and are today in great disrepute. Not only have these drugs been condemned, but many a physician's reputation has been jeopardized by these so-called "allergic panaceas." We, as physicians, will find it folly to promise results such as those claimed by the sponsors of such drugs. Benadryl is second only to epinephrine in acute urticaria and sêrum sickness. It is first in chronic urticaria and angioneurotic edema and has been helpful in Meniere's and thermal allergy. Reliable statistics for hay fever remain to be evaluated after benadryl has been used throughout several ragweed seasons. Bronchial asthma, the real challenge to the allergist, has not responded to its use. The results in migraine are also very disappointing.

Untoward effects of this drug are not geographical, as Dr. Bowen pointed out, and serious difficulties may be experienced. Reactions in coal tar sensitive individuals may be castastrophic. One cannot disregard known or demonstrable clinical allergies.

In conjunction with allergic supervision, I have found benadryl a very potent part of the therapeutic armamentarium.

The unfortunate thing about this excellent drug, benadryl, is that it is being dispensed at random to the public at the local pharmacy. As in the past with many other drugs, this practice will lead to serious accidents, and statistics of benadryl's merit will not be accurately correlated.

Dr. Bowen (closing): I wish to express my sincere thanks to Dr. Braden and Dr. Seibold for their confirmatory observations.

The drowsiness experienced by a patient after taking benadryl may be lessened if the drug is prescribed *only* after meals. It should also be remembered that benadryl has an atropine-like reaction. This quality may explain some of the failure in its use in the treatment of the asthmatic, for there the opposite effect is desired.

There is never justification for combining atropine and benadryl in any prescription.

The elixir mentioned earlier consists of glycerin, alcohol (14.6 per cent), sugar, and flavors: oil of cinnamon, oil of orange, oil of cloves, coriander (synthetic), and cinnamic aldehyde.

It should be remembered that benadryl is an excellent drug for the allergice patient but is not a substitute for allergic study.

LACK OF HEART PAIN IN NEGROES

Coronary thrombosis, one of the leading causes of death in this country, is as common among Negroes as it is among white people, according to William S. Hunter, M. D., of Louisville, Ky. However, since the Negro rarely has pain it is not usually diagnosed as heart disease before death.

Writing in the May 4 issue of *The Journal of the American Medical Association*, Dr. Hunter says that "it seems likely that between 2,800 and 4,600 Negroes in the United States are killed every year by myocardial infarction and that many more are disabled by the condition."

Dr. Hunter, who is from the Departments of Internal Medicine and Pathology, University of Louisville Medical School, suggests that the absence of pain may be due to the fact that high blood pressure had been found to be much more common and much more severe among Negroes than among white people. This condition probably causes an enlargement of the secondary arteries through which the blood is detoured to the heart muscle. Thus pain is eliminated, for it occurs only when some part of the heart muscle is deprived of its necessary blood supply.

THE Rh FACTOR: ANALYSIS OF A ROUTINE Rh TESTING SERVICE

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The recognition of the clinical importance of the Rh factor has resulted in increased safety of transfusions and more accurate diagnosis and treatment of hemolytic disease of the newborn. The experience with Rh testing accumulated in the William Buchanan Blood, Plasma and Serum Center since July 31, 1942, has not only indicated the importance of such studies but also has demonstrated the necessity of routine Rh typing. Such a routine was instituted on June 14, 1944, with Rh typing of every mother and infant, and two weeks later Rh typing of all donors and recipients. During this time a careful search for antibodies in mothers and infants has been made not only in all cases of erythroblastosis, but also whenever an Rh negative mother has an Rh positive child. In an earlier period, from July 31, 1942, to June 13, 1944, extensive studies for Rh antibodies as well as Rh typing were conducted on all clinical cases of erythroblastosis but routine Rh typing was not done. An analysis of the results of this Rh testing service seemed worth while in order to help establish the clinical importance of routine Rh typing and the search for Rh antibodies in cases of erythroblastosis, and in cases of severe or hemolytic transfusion reactions.

The serological background of Rh isoimmunization has been outlined in simplified form by the present authors[4] in a paper presented before an earlier meeting of this society. Briefly the Rh factor is an antigen present in the erythrocytes of approximately 85 per cent of the general population but lacking in the erythrocytes of the remaining 15 per cent. Those not having the Rh factor in their red cells do not have naturally occurring antibodies in their serum as in the cases of the regular blood types but can develop anti-Rh agglutinins only as a result of introduction of Rh positive erythrocytes into their circulation or tissues. Fortunately not all Rh negative persons appear capable of producing such antibodies even when Rh positive red cells are injected. It has been stated that only about 2.4 per cent of negative persons may respond to the Rh antigen with antibody production.[14]

The clinical importance of Rh isoimmunization lies in the fact that persons carrying Rh antibodies can be given blood transfusions safely only if Rh negative donors are used. Furthermore, when the isoimmunization is the result of pregnancy with an Rh positive fetus, erythroblastosis of the infant may result from absorption of antibodies by the fetus through the placenta from the mother. This situation not only involves great risk to the mother if transfusions are required but also may result in severe hemolytic destruction of the Rh positive cells of the newborn with resultant anemia, icterus gravis, or fetal hydrops. For a more detailed review of the subject reference should be made to Landsteiner and Wiener,[10] Levine and Stetson,[12] and the comprehensive reviews of Levine,[11] Diamond,[2] and Wiener.[15]

Results of Rh studies in respect to transfusions fall into two periods, the first from July 31, 1942, to July 27, 1944, and the second from the institution of routine Rh typing to April 23, 1946. During the first period a total of 5 cases of transfusion reactions due to Rh isoimmunization occurred in Baylor Hospital. Detailed studies of these cases together with 2 others have been reported previously.

Of the 5 cases occurring in Baylor Hospital, 4 showed Rh antibodies in the serum, but only 2 exhibited obvious clinical signs of hemolysis in the form of icterus. One case, the last of this group, terminated fatally. As far as can be determined this is the only case of hemolytic transfusion reaction terminating fatally during the entire two periods studied during which 17,012 transfusions were given from the Buchanan Center. A study of this one fatal reaction led to the conclusion that it could have been prevented only by means of a completely routine Rh service in which all donors and recipients were Rh typed. Accordingly, this routine was immediately instituted in spite of the uncertainty of obtaining sufficient Rh typing serum to continue this service. Fortunately a fairly large supply of relatively high titer Rh serum from an isoimmunized mother was already available from the obstetric service. Before this supply of serum was exhausted, a method of producing ample quantities of high titer Rh serum had been developed and reported.[8]

Since the institution of completely routine Rh typing for all transfusions, there has been only one hemolytic reaction from Rh isoimmunization. In this case, a white woman, age 29, was admitted to the hospital because

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of continued and excessive menstruation. No history of previous transfusions or abortions was obtained until after the transfusion reaction, when further questioning revealed that the patient had received two transfusions at age 15, one of which was from the patient's Rh positive father. The patient had also had an abortion approximately three months prior to admission. The patient was typed Rh positive and 500 cc. of Rh positive blood was given. A severe hemolytic transfusion resulted with nausea, vomiting, chills, and fever followed by hematuria, oliguria, and a decrease rather than an increase in the erythrocyte count. Investigation of this reaction showed that the patient was not Rh positive but Rh negative with anti-Rh agglutinins in her serum. The Rh testing serum which had been used for this case was found to be heavily contaminated with bacteria from failure to keep it refrigerated. This contaminated serum agglutinated both Rh positive and negative blood samples on retesting. The patient recovered after administration of four units of plasma and four transfusions of Rh negative blood over a period of eight days.

This case is the only instance of hemolytic transfusion reaction due to Rh isoimmunization observed since the inauguration of routine Rh typing for transfusions. During this time (from June 27, 1944, to April 23, 1946) 10,680 transfusions were given.

In this same period two probable hemolytic reactions were definitely prevented by the routine Rh service. In the first of these 2 cases, a crossmatch with Rh positive blood showed slight signs of agglutination on the same day that routine Rh typing was first instituted. Rh typing of the patient showed a negative test and examination of the pilot tube saved from a transfusion given a few days earlier demonstrated that the patient had received Rh positive blood. A test for antibodies on the patient's serum showed a titer of 1:320 against Rh positive cells. A second transfusion of 500 cc. of Rh negative blood was uneventful. For this case routine Rh typing was started just in time!

The second case in which hemolytic transfusion reaction seems to have been prevented was that of a woman, age 25, who was admitted to the hospital for a possible pelvic abscess following laparotomy. Because of her low erythrocyte count of 2,900,000 a transfusion was ordered. The husband, a physician, said that he had given two transfusions to the patient and offered himself as donor, stating that he was Rh negative. The routine test, however, showed he was Rh positive and accordingly the patient's serum was tested for antibodies to determine if Rh isoimmunization had occurred. No agglutinating antibodies were found, but the blocking and developing tests were positive, thus demonstrating the presence of incomplete Rh antibodies or immune globulins. Two transfusions of Rh negative blood were given without difficulty.

A study of the problem of erythroblastosis in the Florence Nigthingale Maternity Division of Baylor Hospital suggests a logical division into three periods. The first period, from July 31, 1942, to June 13, 1944, extends from the start of Rh testing in isolated cases showing clinical signs of erythroblastosis to the time when routine Rh studies on all mothers and infants were instituted. Table 1 shows an analysis of cases of hemolytic disease of the newborn due to Rh isoimmunization diagnosed during this period. It should be noted that the testing of mothers and infants to determine the Rh type and the examination of the blood for antibodies was essentially a laboratory check of a diagnosis already made on clinical grounds. Of the 9 cases of erythroblastosis, 7 patients lived and 2 died, a mortality rate of 22 per cent.

TABLE 1.—*Analysis of Erythroblastosis Cases, July 31, 1942, to June 13, 1944.*
(Rh Testing on Request Only, Not Routine.)

Mothers	
Total Mothers with Erythroblastotic Infants	9
Mothers with Rh Antibodies	8 (88.8%)
Mothers without Antibodies	1 (11.2%)
Infants	
Infants with Antibodies in Serum	1
Infants with Antibodies in Cord Eluate	1
Infants with No Antibodies Found	5
Total Births During Period	5,400
Ratio Erythroblastosis to Total Births	1:600 (.16%)

Routine Rh studies on all mothers and infants were started June 7, 1944, about two weeks earlier than on the transfusion service. The routine consisted of Rh typing of all mothers and infants and a test for antibodies in all cases where the mother was Rh negative and the infant Rh positive. The test tube method of Levine[12] and the blocking test of Wiener[13] were used for the demonstration of antibodies during this second period. In addition, the red cells of the infant were tested for adsorbed antibody by the elution technique of Landsteiner and Miller.[9] Evaluation of these techniques and detailed results of their use are reported elsewhere.

Table 2 gives an analysis of the cases of erythroblastosis diagnosed during this period of routine Rh testing from June 14, 1944, to February 22, 1946. These diagnoses were based not only on clinical observations but also on the finding of antibodies in mother

or child or both. In several cases a tentative diagnosis was made before birth and Rh negative blood was made available at time of delivery for treatment of the infant. In the 15 cases of erythroblastosis 2 infants were stillborn, and 1, a hydrops fetalis, lived only forty-five minutes. This gives an over-

TABLE 2.—*Analysis of Erythroblastosis Cases, June 14, 1944, to February 22, 1946.* (Routine Rh Typing.)

Mothers	
Rh Negative with Rh Positive Infants	63
Total Cases Erythroblastosis	15*
Rh Negative Mothers with Affected Infants	14* (3.88%)
Mothers with Antibodies	13 (92.8%)
Mothers of Affected Children, No Antibodies	1
Mothers with Antibodies, No Clinical Erythroblastosis	2
Infants	
Antibodies in Serum	3
Antibodies in Eluate of Cord Erythrocytes	3
No Antibodies Found	9
Total Mothers Typed	5,450
Ratio of Erythroblastosis To Total Mothers	1:363 (0.27%)

*The difference in mothers (14) and erythroblastotic infants (15) is due to one set of identical twins with this disease.

all mortality rate of 26.6 per cent, or if the stillborn cases are omitted, 15.3 per cent. Omission of the hydrops fetalis case would lower the rate still further to 8.3 per cent.

A third period in the Rh studies of erythroblastosis was opened on February 23, 1946, when a new routine was added to the laboratory Rh service, namely, the use of anti-human globulin serum as a "developing" test to show anti-Rh antibodies or immune globulins not demonstrable with other tests. While this test, first described by Coombs, Mourant, and Race,[1] is discussed and evaluated in other papers by the present authors,[5, 6] it should be noted that the test acts by causing agglutination of any red corpuscles coated with specifically adsorbed human globulin (antibodies). Its specificity depends on the choice of red cells. For example, type O Rh positive red cells added to serum containing Rh antibodies will specifically adsorb the antibody. If the antibody is of the agglutinating type, clumping will occur; if of the incomplete or blocking type, the blocking test will be required. However, a possible third order of antibody was suggested by the finding in some sera of high antibody titers detectable only by the developing test. This antibody could be demonstrated only after specific adsorption on known Rh positive erythrocytes followed by washing these red cells to remove mechanically adherent serum protein, and addition of the anti-human globulin "developing" serum to bring about observable agglutination. In the case of fetal red cells suspected of carrying adsorbed anti-Rh immune globulins it is necessary only to wash the cells three times with physiologic saline solution and add the developing serum.

Because of its specificity and high sensitivity, this test was adopted not only as a test for maternal antibodies but also as a possible diagnostic test for erythroblastosis. It was noted that cases of erythroblastosis were observed in which the maternal antibodies were predominantly of the type brought out only by the developing test. Furthermore, in some instances a positive developing test on infant erythrocytes was the only clinical or laboratory sign of erythroblastosis initially observed. For these reasons it was deemed of importance to establish the hemolytic activity of the immune anti-Rh globulin not demonstrable with the agglutinating or blocking tests but positive to the developing tests. We were able to demonstrate this hemolytic action of the anti-Rh immune globulin in vitro with the same technique used previously by Hill and Haberman[6] to show hemolysis of erythrocytes by anti-Rh agglutinins. A description of this demonstration that immune globulin (developing test) Rh antibodies exhibit at least as great in vitro hemolytic activity as the classical agglutinating Rh antibody is presented elsewhere.[7]

TABLE 3.—*Analysis of Erythroblastosis Cases, February 23, 1946, to April 23, 1946.* (Developing Test Added to Routine.)

Mothers	
Rh Negative with Rh Positive Infants	63
Total Mothers with Erythroblastotic Infants	5 (7.9%)
Mothers with Rh Antibodies	4 (80%)
Mothers without Antibodies, Infants with Antibodies on Red Blood Cells	1
Infants	
Antibodies in Serum	2
Antibodies in Erythrocyte Eluate	1
Antibodies Adsorbed on Red Blood Cells (Developing Test)	4
Total Mothers Rh Typed	586
Ratio Erythroblastosis to Total Mothers	1:117 (0.85%)

Table 3 shows an analysis of cases during one month of routine use of the developing test to demonstrate antibodies. While this is a relatively short period of time for accurate statistics, more than 500 mothers were Rh typed, and 63 Rh negative mothers with Rh positive infants were found. A positive developing test indicating adsorbed Rh antibody was found in each erythroblastotic infant examined. In 1 case, that of a macerated fetus, no blood was obtained for this test. However the mother's serum showed a titer of 1:2,048 with the developing test justifying a positive diagnosis of erythroblastosis. Of the 4 remaining cases 2 were clinical erythroblastosis and 2 were subclinical. Of the latter 1 required no treatment and the evidence of erythroblastosis consisted solely of the developing test, although the history of previous transfusions with an earlier pregnancy was suggestive of

possible Rh isoimmunization. The last case of erythroblastosis exhibited Rh antibodies in the mother's serum with an agglutinating titer of 1:1 and a developing titer of 1:64 but a negative blocking test. The infant's serum showed identical antibody titers but the erythrocyte eluate was negative. However, the developing test on the infant's red cells was 3 plus, indicating specific absorption in vivo of the Rh immune globulin. Clinically the infant showed only slight and transient jaundice. No treatment was required. No history of previous pregnancies or transfusions could be obtained. In this series of 5 cases of erythroblastosis the only mortality was in the case of the macerated fetus.

DISCUSSION

The results herein reported indicated the marked reduction of hemolytic transfusion reactions due to Rh isoimmunization that may be brought about by routine Rh typing. In the single instance of an Rh hemolytic reaction since routine testing, errors in typing due to growth of bacteria in improperly cared for antisera were responsible for the giving of Rh positive blood to an Rh negative patient.

This type of error is most apt to be a problem where an attempt is made to preserve substantial quantities of Rh antisera in liquid form. This problem is further complicated by the fact that antiseptics used as bacteriostatic agents tend to cause deterioration of the Rh agglutinins. The procedure adopted in this center has been to vacuum dry high titered Rh antiserum in 1 cc. ampoules which are high vacuum sealed. After 1 cc. quantities are made up by addition of saline solution, constant refrigeration permits use of this material for about two weeks. This availability of potent serum renders routine Rh typing feasible even for small hospitals.

The use of anti-human globulin serum as a developing test in the detection of adsorbed antibodies offers definite advantages for special transfusion problems. For example, in "rough" or doubtful cross match reactions it can be used to differentiate nonspecific effects such as those due to high globulin levels in the patient's serum from those due to specific antibodies for erythrocytes. The test is particularly valuable in this connection because it will demonstrate such specifically adsorbed antibodies whether complete (agglutinating), incomplete (blocking), or immune globulin (developing). Antibodies against any erythrocyte antigen may be demonstrated in serum with the developing test if test erythrocytes containing the proper antigen are available. In transfusion problems this may be assured by using the erythrocytes of the donor suspected of isoimmunizing the patient. These red cells are then tested with developing serum after they have been subjected to suspension in the patient's serum and subsequent saline washing. This approach may largely solve the problem of transfusion reactions in cases of Rh sub-group isoimmunization heretofore hampered by the great scarcity of antisera against some of the Rh sub-groups.

The marked increase in the percentage of cases of erythroblastosis diagnosed on the obstetrical service correlates with the improvements in Rh techniques. During the first period when Rh typing was not routine and diagnosis was essentially clinical there was only 1 case of erythroblastosis out of each 600 births. After routine Rh typing and testing for antibodies was adopted the ratio dropped to 1 in 363 births, while in the short period of one month since use of the developing test, 5 cases out of 586 births or a ratio of 1:117 was observed. While a much larger series must be studied to determine this true ratio, it seems unlikely that the percentage of cases of erythroblastosis will increase. The developing test is sufficiently sensitive so that even subclinical cases are detected. On the other hand, experience so far indicates complete specificity, as shown by negative results in tests performed on large numbers of newborn infants including stillborns and cases of jaundice in Rh negative infants and in Rh positive babies of Rh positive mothers. The test was also negative in an infant with pulmonary atelectasis showing numerous erythroblasts in the blood smear. Accordingly, it is believed that the developing test as applied to the red cells of newborn infants constitutes a diagnostic procedure for erythroblastosis. It should be pointed out that this test should also detect this disease when due to anti-A or anti-B agglutinins absorbed from the mother and affecting A or B erythrocytes of the infant.

Reference to tables 1, 2, and 3 in respect to the detection of maternal antibodies shows a relatively high percentage of positive results in all periods of study. In the first period using only the agglutinating test, 88.9 per cent of cases showed maternal antibodies as compared to the 50 per cent sensitivity usually stated for this method.[3] In the second period the addition of the blocking test increased the percentage of maternal antibodies detected to 92.8 per cent. In the third period the lower percentage of 80 probably reflects the increased accuracy of diagnosis of erythroblastosis and the detection of mild subclinical cases in which the low concen-

tration of antibodies becomes relatively concentrated on the fetal erythrocytes over a period of time.

A suggestion relative to the possible percentage of Rh negative persons susceptible to isoimmunization may be gained from table 3. Here it may be noted that the 5 cases of erythroblastosis out of the 63 Rh negative mothers with Rh positive infants seen during this period represent 7.9 per cent isoimmunization. This included primiparas and cases isoimmunized by transfusion. It seems likely that an even higher percentage of Rh negatives may be capable of isoimmunization. Further studies with the developing test for antibodies in Rh negative mothers should clarify this point.

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ABSTRACT OF DISCUSSION

Dr. Arild Hansen, Galveston: It is a pleasure for me to be asked to discuss this very fine presentation. It is heartening to know that a great deal is known about a problem which but a few years ago was as mysterious and baffling as leukemia is today. Often I have wished that my investigative work was in this field as it is indeed difficult to keep up with the rapid advances being made. The authors have brought to our attention another advancement in the so-called "developing test" which enhances diagnostic acumen and aids further in handling the case.

During the past two decades pediatricians in our country have given transfusions as supportive therapy in perhaps excessive numbers. Naturally, we wonder about the harm or potential danger of such a practice. The more radical individuals or reactionary persons may tend to condemn this practice; however, the good resulting from such practice undoubtedly outweighs this potential danger according to a number of our confreres. A few months ago we had on our service a young girl who had a marked transfusion reaction, and it was learned that she had had a transfusion seven years previously. Agglutination studies were not performed; however, we could not help but ask ourselves, "How often does this occur?" Undoubtedly, many a child or infant Rh negative has been transfused with Rh positive blood.

Again, let me congratulate the authors on their well controlled studies, and I trust they will be able to make contributions toward the ultimate goal of prevention of the erythroblastotic infant in the mother who has previously given birth to infants with one of the manifestations of this serious disorder.

RECENT ADVANCES IN Rh TESTING

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and
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The necessity for routine determination of the Rh antigen in all blood donors and recipients as well as in all pregnancies and newborn children has stimulated further research in methods of testing for the Rh antigen of the erythrocytes and the Rh antibody which is present in the isoimmunized patient. The early impetus for more accurate tests for the Rh antigen was due to the inadequate supply of Rh testing serum of high potency and specificity. The majority of isoimmunized persons possessed sera that was low in agglutination titer or showed no agglutinins by the tests then available. At that time it was recommended that no serum should be used with titer of less than 1:20. To make more of this serum of low potency usable, new techniques of greater sensitivity were sought.

The tube method as used in the laboratory is essentially the test described by Levine and Stetson.[9] A 2 per cent erythrocyte suspension is prepared from the blood to be tested. One drop of this suspension is placed in a tube having a 7 mm. inside diameter and 8 cm. long, and to this is added 1 drop of anti-Rh serum. The tube is shaken thoroughly to mix the cells and serum and then placed in a 37 C. water bath for thirty minutes to one hour. After the incubation, the tube is centrifuged slowly at 500 r. p. m. for one minute. The sediment is then agitated lightly and examined in the tube under the low power of the microscope by placing the tube on the microscope stage in a horizontal position and observing for clumps. The proper magnification may be obtained by removing the lower lens of the low power objective.

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From the William Buchanan Blood Plasma and Serum Center of Baylor Hospital and the Department of Clinical Pathology, Southwestern Medical College.
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The test for the Rh antigen as recommended by Landsteiner and Wiener[8] has been widely used. In this method 2 drops of testing fluid are mixed with 1 drop of a 2 per cent erythrocyte suspension in a 7 mm. diameter Kahn type tube. The tube is incubated at room temperature for one hour before examination of the sediment with a hand lens through the base of the tube. Negative bloods show a circular deposit of cells with a smooth edge, while positive bloods show a wrinkled edge or a granular deposit.

The capillary test devised by Chown[1] has been used extensively in the Buchanan Blood Center. In a series of 1,000 comparative tests between the test tube method and the capillary method of typing the Chown capillary test showed the same specificity and a greater sensitivity than the tube method. The significant results obtained using a saline diluted typing serum with the capillaries has resulted in the adoption of this method for our routine Rh typing. The blood of the person to be tested is collected in citrate, oxalate, or heparin. For the best results the glass capillary tubes to be used must be from 0.3 mm. to 0.6 mm. inside diameter and 8 cm. long. The capillary is dipped into the anti-Rh testing serum until a column of 2 cm. of serum rises in the tube by capillary attraction. The charged end of the capillary is then dipped into the blood, allowing an equal quantity of blood to enter. To avoid having bubbles between the antiserum and blood interface, the tube is kept perpendicular to the blood sample when the dipping is done. After the tube is charged, it is tipped back and forth to mix the antiserum and blood. The tube is then set at a 45 degree angle in a rack having a plasticine base. The rack should be white in color to facilitate readings. The test is incubated at room temperature for fifteen minutes before the final reading is made. An Rh negative blood forms a long smooth fine line along the length of the capillary tube while Rh positive blood forms beaded threads or a series of bands of agglutinated erythrocytes on the lower wall of the capillary. The reaction may be read with the naked eye or with a hand lens.

It has been found that some sera cause false positive reactions with this test. However, this may be avoided by a three or four times dilution of the test serum. The serum used in this laboratory is prepared from human sources[7] and has an original titer of from 1:30,000 to 1:50,000. Consequently, in use it is diluted with saline solution to give a final titer of approximately 1:200. This saline dilution eliminates false positive reactions that are sometimes seen with undiluted human typing serum.

The determination of the Rh type is a relatively simple procedure when antiserum of sufficient potency and proper specificity is used, especially with the capillary technique. Any of the above described tests are adequate in the hands of an experienced worker. However, the detection of antibodies in a sensitized person has presented many difficulties. When the classical agglutination test is used as the sole method of detection of isoimmunization, not all sensitized persons will show demonstrable agglutinins. This failure to correlate demonstrable antibodies and isoimmunization has led to intensive investigations to improve the methods of detecting antibodies in the patient's serum.

In 1944 Race[10] and Wiener[11] reported the finding of Rh antibodies that adsorbed on Rh positive cells but failed to produce visible agglutination. Wiener labelled these antisubstances "blocking" antibodies, because they specifically adsorbed on the Rh antigen and neutralized it. When Rh typing serum of known potency is added to erythrocytes treated with blocking serum, no agglutination occurs, showing an interference which is due to the previous saturation of the Rh hapten of the erythrocytes by the blocking antibody. The test for antibodies of the blocking variety[11] is of value in studying the sera of patients showing Rh sensitization. The use of this test somewhat improves the examination for antibodies in that many sera have the blocking antibody in sufficient quantity to prevent the classical agglutinin from making itself evident. Wiener has shown that the blocking antibody adsorbed on the Rh antigen faster than the agglutinin, and by so doing causes the agglutination test to appear negative. If sera that show this blocking effect are diluted serially and tested for agglutination, it is frequently noted that a prozone exists in the lower dilutions. As dilution is increased, the effect of the blocking antibodies disappears and agglutination may be seen in the higher dilution.

In 1945, Diamond and Abelson[3] noted the blocking effect described by Race and Wiener and devised a slide test for the detection of antibodies that apparently is not affected by the blocking antibodies. In this test 0.1 cc. of patient's serum is mixed with 0.2 cc. of a 50 per cent suspension of Rh positive cells or 0.2 cc. of Rh positive blood on a slide. The slide is warmed to 37 C. and rocked in the manner of a Kline test for approximately five minutes. The slides are then observed for clumping which indicates the presence of anti-Rh agglutinins.

In the same year, Wiener[12] described the "conglutination" test for the demonstration of anti-Rh agglutinins in the sera of sensitized patients. In this test, the 2 per cent erythrocyte suspension is made in normal serum or plasma from AB bloods. The test is performed in the tube in the same manner as described by Landsteiner and Wiener.[8]

A new approach to the problem of the detection of isoimmunization was made by Coombs, Mourant, and Race.[2] An anti-human globulin serum was produced which would cause sensitized erythrocytes to agglutinate where they would not do so before. When Rh positive cells are suspended in serum containing blocking or incomplete antibodies, the erythrocytes adsorb the antibody without visible agglutination. If these sensitized erythrocytes are washed in saline solution by centrifugation to remove nonspecifically adherent globulin and then treated with the anti-human globulin serum, visible clumping occurs. By this method, it is possible to detect antibodies in sensitized persons when the usual tests fail to do so.

In the studies on additional evidence of the pathogenesis of erythroblastosis, Hill and Haberman[5] found that the anti-human globulin serum is an important serological adjunct to the investigation of isoimmunization whether by pregnancy or transfusion. When the incomplete or blocking antibody is adsorbed on Rh positive erythrocytes, no observable agglutination occurs but the cells are coated with the anti-Rh globulin. This adsorption resists saline washing which will remove other serum proteins. When the anti-human globulin serum is added to such washed erythrocytes, its action upon the specifically adsorbed anti-Rh globulin causes agglutination of the globulin coated erythrocytes. The action of this serum is to develop an observable agglutination where the specifically adsorbed antibodies fail to do so. Because of the analogy to the photographic development of a visible image, we have suggested that the term "developing serum" be applied to the Coombs, Mourant, and Race[2] anti-human globulin serum. In the report on a series of cases of erythroblastosis, after adoption of the developing test as part of the routine studies on newborn children and mothers, Hill and Haberman[5] found that all of the cases showed antibodies with this new technique when the agglutination and blocking tests failed. Furthermore, greatly improved correlation between antibody titer and the severity of the case was found when the developing test was used. Further use of the developing serum showed that the red blood cells of infants having erythroblastosis would clump when suspended in this serum because the child's erythrocytes were coated in vivo with the antibody produced by the mother. This developing test on washed newborn erythrocytes was suggested as a diagnostic test for erythroblastosis. The differentiation of erythroblastosis from other diseases of the newborn, such as stillbirths and physiologic jaundice, has been a difficult clinical problem. Not all sensitized mothers produce detectable agglutinins or blocking antibodies. Since stillbirths and jaundice may be the result of causes other than isoimmunization by the Rh factor, the determination of the antibodies in the mother is of the utmost importance for differential diagnosis. Because of this difficulty, the developing test has been employed routinely in our maternity service to establish its diagnostic value in differentiating erythroblastosis from the other diseases of the newborn.

METHODS

Test for Agglutinins.—A 2 per cent suspension of a suitable O Rh positive cell is prepared. One drop of these erythrocytes is mixed with 1 drop of patient's serum in a tube 7 mm. inside diameter and 8 cm. long. The tube is placed in a 37 C. water bath for 1 hour. After incubation, the tube is then centrifuged lightly (500 r. p. m.) for one minute. The tube is lightly agitated and observed under the lower power of the microscope. If clumping occurs, agglutinins are present.

Blocking Test.—If the above test shows no clumping, 1 drop of anti-Rh typing serum of known potency is added to the erythrocyte suspension. The tube is again incubated at 37 C. for one hour. At the end of the second incubation the cells are observed for agglutination. If clumping occurs, the serum of the patient possessed no blocking antibodies. If no clumping occurs, the patient's serum contained blocking antibodies which coated the erythrocytes but failed to produce agglutination. This saturation of the Rh antigen prevented the Rh antibodies of the typing serum from acting to give visible clumping.

Developing Test on Patient's Serum.—One drop of the serum to be tested is mixed with 1 drop of a 2 per cent suspension of type O Rh positive erythrocytes in a Kahn type tube. This is incubated for one hour at 37 C. and observed for agglutination. If no clumping is observed the cells are washed three times in saline solution by centrifugation to remove unadsorbed globulins. After the third wash, 1 drop of developing serum is added to the sedimented cells after the saline has been removed. The cells are suspended and in-

cubated for one hour at 37 C. At the end of this second incubation, the tube is centrifuged at 500 r. p. m. for one minute and observed for clumping. Agglutination indicates the presence of adsorbed immune globulin.

Developing Test on Erythrocytes.—The erythrocytes of cord blood are suspended in saline solution and washed three times to remove nonspecifically adherent proteins. The cells are then made up as a 2 per cent suspension. One drop of the suspension is added to 1 drop of developing serum in a tube (7 mm. inside diameter and 8 cm. long) and incubated at 37 C. for one hour. At the end of this incubation period the tube is centrifuged at 500 r. p. m. for one minute, and observed for agglutination. Clumping of the erythrocytes indicates that antibodies had been adsorbed in vivo.

RESULTS

The material presented in table 1 represents the studies on the serum of 5 mothers who had given birth to children having erythroblastosis. In case 1 the agglutinating titer of the maternal serum was very weak

TABLE 1.—*Data from Studies on Serum of Five Mothers Who Gave Birth to Children with Erythroblastosis.*

	Rh Antibody In Maternal Serum			Antibody On Red Blood Cells	Diagnosis
	Agglutination	Blocking	Developing	Developing Test	
Case 1	1:12	....	1:64	+ + + +	Hemolytic anemia with mild jaundice
Case 2	....	1:2	1:16	Not Available	Hemolytic anemia
Case 3	1:2	1:32	1:2,048	Mascerated fetus	Hydrops fetalis
Case 4	1:128	....	1:128	+ + + +	Icterus gravis
Case 5	1:1	....	1:64	+ + +	Mild icterus

and no blocking antibody was demonstrated. However, the developing test showed a titer of 1:64. In case 2, no agglutinins were found but a blocking titer of 1:2 was present. The developing titer was 1:16. The cord cells were not available because the case was referred from another hospital. In case 3, the mother of a hydrops fetalis showed only 1:2 agglutinating and 1:32 blocking titer in her serum. When the developing test was used her serum showed a titer of 1:2,048. In case 4 the agglutinating and developing titers were equal, but no blocking antibody was observed. In case 5 a very weak agglutinin in the undiluted maternal serum was found, but no blocking was observed. The developing titer was 1:64. In all the cases presented the developing titer equaled or exceeded the agglutinating or blocking titers. These cases will be presented in detail elsewhere.

The developing test was applied routinely on all deliveries at the Florence Nightingale Maternity Hospital. In a period of sixty-two consecutive days 424 cord bloods were studied.[6] Four cases of erythroblastosis, 17 cases of jaundice of the newborn, 15 stillbirths, and 1 case of atelectasis are presented in table 2. The case of atelectasis is of interest in that the child's blood showed 50 erythroblasts and 20 normoblasts per 100

TABLE 2.—*Data from Routine Application of Developing Test to Deliveries.*

Diagnosis	No. of Cases	Developing Test On Cord Red Blood Cells
Erythroblastosis (Icterus Gravis)	2	+
Erythroblastosis (Hemolytic Anemia)	1	+
Erythroblastosis (Subclinical)	1	+
Atelectasis with Erythroblasts	1	—
Jaundice of the Newborn	17	—
Stilbirths other than Erythroblastosis	15	—
Normal Births	387	—

white blood cells, thus showing one of the laboratory findings associated with erythroblastosis fetalis but due to another cause (oxygen want).

DISCUSSION

The detection of the Rh antigen is now a relatively simple procedure when a potent antiserum of the proper specificity is available. At the William Buchanan Blood Center the Chown test is used in the routine typing performed on all donors, recipients, mothers, and newborn children. The reactions obtained are clear and easily read within three to ten minutes. If a rare doubtful reaction occurs, it is repeated in the capillary and also checked with the test tube method. The sera prepared from human sources[4] are preferred to those prepared in animals with the erythrocytes of Macasus rhesus. The serum from immunized animals gives positive reactions with cord erythrocytes irrespective of the Rh type as determined by anti-Rh serum from human sources.[4]

The many tests for the detection of Rh antibodies in isoimmunized persons have been devised to circumvent the activity of the blocking or incomplete antibody. The methods devised by Wiener, and by Diamond and Abelson have been superior to the agglutination test. However, the method of Coombs, Mourant, and Race has offered an entirely new approach to the detection of isoimmunization in human beings which appears to solve this problem completely. The use of this serum will not only detect Rh iso-

immunization, but also those caused by the Hr, A, B, and other antigens of human blood. The developing serum is not specific for the Rh antibody, but this anti-human globulin serum reacts with any globulin from human sources whether immune or nonimmune. The specificity of the test rests on the selection of the antigen to be used. For example, when sheep erythrocytes are used in the test for infectious mononucleosis, the antibody produced in human beings that reacts with the sheep red blood cells will be adsorbed. If blocking or incomplete antibodies that fail to give agglutination are present, the developing serum will cause the adsorbed immune globulins to agglomerate, carrying the sheep erythrocytes with them, and giving what seems to be agglutination of the blood cells. Consequently, the developing serum will have broad applications in conditions where incomplete antibodies may interfere with serological diagnosis.

The demonstration of the blocking antibody has shown the independence of the two phases of the agglutination reaction. In the case of the agglutinin, specific adsorption followed by clumping is seen. In the case of the blocking antibody, an immune antibody exhibits specific adsorption without the classical visible effect, agglutination. In the present study, a third order of antibodies is demonstrated by the results in table 1. Cases 1 and 5 showed agglutinating antibodies to a titer of 1:2 and 1:1, respectively, while no blocking antibodies were found. However, titration of the patient's serum, using the developing serum, demonstrated that adsorbed immune globulin was present at titer of 1:64 in both cases. In case 2, no agglutinins were found, but a blocking titer of 1:2 and a developing titer of 1:16 existed in this serum. In case 4, there were no blocking antibodies, and the agglutinin and developing titers were equal, indicating that probably only the agglutinin was present. Case 3 offers good evidence of the individuality of the three orders of antibodies. This serum showed an agglutinating titer of 1:2, a block through a dilution of 1:32 and a developing titer of 1:2,048. This wide differential between the three reactions, as well as the evidence in the other cases, indicates that the immune globulin demonstrated here indicates a third order of antibodies with respect to valence. Further evidence will be presented elsewhere.

The application of the developing serum to cord erythrocytes offers a means of differential diagnosis between erythroblastosis and such confusing conditions as jaundice of the newborn. In the 1 case of atelectasis studied, the picture of compensatory hemopoiesis, which is so often seen in erythroblastosis, was not due to isoimmunization as shown by the negative developing test. Likewise jaundice and stillbirths not due to isoimmunization are eliminated. In 1 stillbirth that gave a negative developing test, the fetus was Rh positive and the mother Rh negative. It is of interest to note that this test was positive in an Rh positive child of an Rh negative mother who gave the clinical history of multiple pregnancies and transfusions. However, this child did not develop clinical erythroblastosis.

It is believed that the use of the developing serum will improve the correlation between the maternal anti-Rh titer and severity of the condition of the case of erythroblastosis. Also, the developing reaction on the erythrocytes of the newborn can be used as a diagnostic laboratory test for erythroblastosis.*

We wish to express our appreciation to the Obstetrical Staff of Florence Nightingale Hospital and to Sister M. Celestia of Mother Francis Hospital, Tyler, for their coöperation in carrying out these studies.

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ABSTRACT OF DISCUSSION

Dr. William C. Levin, Galveston: Dr. Haberman is to be complimented on his lucid presentation of the techniques used in Rh typing and in the detection of agglutinins and blocking antibodies in the serums of patients suspected of having been sensitized to one of the Rh antigens. In addition, the detection of developing antibodies as has been described is a significant contribution to the Rh problem as a whole.

*Authors' Note.—Since the writing of this paper, the report of R. R. A. Coombs, A. E. Mourant, and R. R. Race (Lancet 1:264 (Feb.) 1946) on the "In-vivo Isosensitisation of Red Cells in Babies with Haemolytic Disease" has become available to us. They found that the addition of anti-human globulin serum to washed newborn babies' erythrocytes would cause agglutination only in cases of hemolytic disease of the newborn. Normal erythrocytes and erythrocytes from obstructive and physiologic jaundice did not agglutinate when treated with the anti-human globulin serum. Similar results were found in studies reported in our paper that confirm the work of Coombs, Mourant, and Race.

With the use of this technique, it seems that the detection of sensitization will be greatly facilitated. Also, it is important to emphasize that now there is available a method with which the diagnosis of erythroblastosis fetalis can conclusively be made.

At the John Sealy Blood and Plasma Bank, we have used the Chown or capillary tube method of Rh typing extensively and have found it to be very satisfactory. I should like to point out, however, that in occasional questionable cases, the test tube method of Levine and Stetson is an invaluable aid in confirming such results. With regard to the Chown technique, I believe that the test is slightly more satisfactory if clotted blood is used. After coagulation and retraction of the clot, a portion of the expressed serum is poured off. Then a heavy suspension of erythrocytes is made by agitating the retracted clot with a stirring rod. The technique is then carried out exactly as outlined by Dr. Haberman.

The techniques now available for work with the Rh factor are becoming simpler and are more reliable than they were a year or two ago. It is hence becoming more and more dependent on the physician to insist on routine Rh typing of every donor and recipient of blood so that sensitization, hemolytic transfusion reactions, and possibly cases of erythroblastosis will be avoided.

PENICILLIN IN THE TREATMENT OF CHRONIC OSTEOMYELITIS

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Penicillin has proven to be extremely effective against penicillin sensitive organisms. The exact role of penicillin therapy in the treatment of chronic bone infections is yet to be determined. It has been shown that the results of penicillin therapy vary considerably in the different clinical types of infections. The results in acute infections without tissue death are quite dramatic, while in chronic infections with tissue death the results are less dramatic and at times even discouraging. The failures should not always be attributed to the drug because chronicity in bone infections introduces factors not present in acute infections. Factors such as mixed infection, fibrosis about a diseased area, sclerosed osteomyelitic cavities, and the presence of sequestra influence the efficacy of penicillin.

The purpose of this study was to evaluate the role of penicillin in the treatment of chronic bone infection.

MATERIAL FOR STUDY

Fifty-eight cases of chronic bone infection were selected for treatment with penicillin. Forty-three or 75 per cent of the patients had previously received one or more courses of sulfathiazole (46 Gm.) over a ten day period with no significant improvement.

Four of the 43 patients had had sequestrectomies plus sulfathiazole postoperatively with no decrease in drainage.

The majority of these patients when admitted to the hospital October 5, 1944, were markedly undernourished. All were given the same 2,500 calory diet and at the beginning of this study, February 18, 1945, they were with one or two exceptions in excellent condition from a nutritional standpoint. Lyons has pointed out that if penicillin is to speed recovery in these chronic cases, protein depletion, disturbed fluid balance, anemia, and hypovitaminosis must be corrected and adequate nutrition maintained throughout the course of treatment.

The wounds in all of these cases had been draining continuously for a period of six months or longer; thus the chronicity of these infections is established.

At the beginning of this study complete blood counts, serum protein levels, urinalyses, and wound cultures were made in each case. The average hemoglobin was 86.5 per cent or 13.6 Gm. per 100 cc. of blood. The serum protein level was 6.7 mg. per 100 cc. The leukocyte and differential counts with a few exceptions were within normal limits.

Cultures taken from all of the 58 cases before treatment with penicillin gave the following results: in 11 of the cases staphylococci were the only organisms cultured and 1 gave a pure culture of streptococci; in 21 cases both staphylococci and streptococci were cultured; in the remaining 25 cases in addition to staphylococci and streptococci a variety of organisms were cultured. These in order of frequency were: Pyocyaneus, diphtheroids, gram-positive micrococci, and the Proteus group. During the course of treatment it was found that the streptococci were more susceptible to penicillin than the staphylococci as was demonstrated by repeated cultures. The Pyocyaneus bacilli were difficult to eradicate. Inactivation of penicillin by secondary contaminants must be recognized as one of the important limitations to penicillin therapy. Meleney has demonstrated in the laboratory that Pyocyaneus elaborates penicillinase, which completely inactivates penicillin in vitro, and it is possible that if we could have controlled this gram-negative bacillus by other medication our percentage of closures might have been higher.

TREATMENT

Since the purpose of this study was to evaluate the role of penicillin in the treatment of chronic bone infections, we subordinated certain well recognized procedures in the orthodox treatment of chronic osteo-

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myelitis. Wounds were dressed every second day. Plaster immobilization was not used for any cases of osteomyelitis of the shafts of long bones unless there was an associated nonunion of a fracture or unless the process involved a joint. Patients without casts were permitted free ambulation.

At the time this study was undertaken penicillin was still a critical item and only limited amounts were available; consequently, we did not use massive doses in any of these cases.

Of the 58 cases of chronic bone infection selected for penicillin therapy, 28 had definite sequestra as shown by roentgenograms. However, the presence of necrosis of bone cannot always be determined from early roentgenograms. Sometimes necrotic bone in the presence of an organism of low virulence does not become separated and may even undergo replacement by living bone.

The 58 cases were divided into three groups on the basis of dosage and method of administration of the penicillin.

Group one consisted of 17 cases, 10 of which showed definite evidence of sequestra by roentgen ray. These patients were given 90,000 units of penicillin per day intramuscularly for fourteen days. At the end of this period six cases (35.3 per cent) exhibited healing of their sinuses. Healing occurred in only 1 of the cases having a sequestrum. The others showed definite clinical improvement as evidenced by decreased drainage which also became thinner and more serous.

Group two consisted of 21 cases, 7 of which had sequestra as shown by roentgen-ray studies. This group was given 150,000 units of penicillin per day intramuscularly for a fourteen day period with the following results: sinuses became healed in 6 cases (29 per cent). Healing occurred in only 1 case that had a sequestrum.

Group three consisted of 21 cases, 11 of which had sequestra as shown by roentgen-ray studies. These patients were given 150,000 units of penicillin per day intramuscularly for a fourteen day period. In addition a penicillin solution, 250 units per cubic centimeter, was instilled locally into the draining sinus twice daily and a gauze wick soaked in the solution was inserted loosely into the sinus tract. The results were evaluated one week after the termination of penicillin therapy. Again sinuses were closed in 6 cases (30 per cent). Healing occurred in only 1 of the cases having a sequestrum. It is our impression that with adequate systemic penicillin therapy the local administration of the drug is unnecessary and even undesirable.

Of the 58 cases, healing occurred in 18 cases (31 per cent). However, 6 reopened within one month; 4 of the 6 closed promptly and remained so after another course of penicillin therapy. In the 2 cases that continued to drain definite sequestra were shown by roentgen study.

A group of 23 cases that did not respond to initial penicillin therapy were selected for further treatment. Twelve of this group had sequestra. Penicillin, 150,000 units per day, was administered intramuscularly for one week followed by 90,000 units daily for another week. In 7 cases not having sequestra healing occurred under this regimen. At the end of the fourteen day period, 2 had closed and in the remaining 5 the drainage became less purulent, decreased in amount, and finally healed in one month without further specific therapy.

Twenty cases that failed to heal under previous penicillin therapy were selected for sequestrectomies. Sixteen cases showed bone fragments by roentgen study, interpreted to be sequestra. The other 4 were explored and proved to have sequestra. Of the 20 cases on which sequestrectomies were performed, 10 healed within four weeks and 3 others healed within six weeks. All patients operated on received 150,000 units of penicillin intramuscularly daily several days before operation and postoperatively for a fourteen day period. As stated before, the extent of bone necrosis cannot always be determined from early roentgen-ray studies. Therefore, if a chronic draining sinus does not close after two or three courses of penicillin, one is justified in exploring the wound for dead bone. This was true in the 4 cases explored and also in other cases which were decreasing postoperative complications. not included in this study.

COMMENT

The response to penicillin therapy in these chronic bone infections was not dramatic and the more experience one has with these cases, the easier it is to understand why. The initial injury followed by a low grade infection produces fibrosis and results in impaired local circulation. Also as the condition becomes more chronic, osteomyelitic cavities become sclerosed, preventing the penicillin from reaching the diseased area in adequate concentrations, and since sequestra have no blood supply it is practically impossible to sterilize them.

In this study of 58 cases of chronic bone infection, some of which were treated with

penicillin alone and some with penicillin and surgery, certain facts were found which we believe are worthy of note.

(1) Penicillin by inhibiting the growth and multiplication of bacteria will arrest infection in cases of chronic osteomyelitis with no sequestra and in a high percentage of cases will allow healing to take place within a short time after the administration of the drug. Sixty-four per cent of our cases closed under specific therapy and with specific therapy and surgery.

(2) Penicillin is of definite value in There was none in our group of operated cases.

(3) With adequate systemic penicillin therapy the local administration of the drug is unnecessary and even undesirable.

(4) Pyocyaneus was present in 16 of our 21 cases that did not respond favorably to penicillin therapy and may well be one of the important causes for failure.

(5) The presence of mechanical factors, such as fibrosis, sequestra, and bone sclerosis, all influence the efficacy of penicillin. Because of the decreased vascularity of the diseased area and the nontoxicity of the drug, it is recommended that comparatively large doses of penicillin be administered, 240,000 units daily, in an effort to increase the local concentration in the affected area.

(6) The use of penicillin will not obviate the need for surgery. Sequestra when present must be removed.

It is only fair to state that a small number of cases might have healed without specific therapy during the five month period covered by this study. We are also aware of the fact that some of the wound closures do not represent cures and may later break down.

A critical analysis of our failures was precluded by the fact that many of our patients were transferred to other installations and therefore further study of them was impossible.

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The practicing physician will do well to request routine laboratory examinations of the sputum of each of his patients with pulmonary symptoms. A number of these persons will be found to have tuberculosis. Most states provide free laboratory service for such tests.—Herman E. Hilleboe, M. D., and Arthur W. Newitt, M. D., Jour.-Lancet, April, 1945.

THE HISTORY OF PSYCHIATRY IN RELATION TO ITS PRESENT PLACE IN MEDICINE

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The present day concepts of psychiatry have been slow in developing, and this is especially noticeable when compared to the advances made in the other fields of medicine. In a measure, this retardation arises from the unwholesome attitude toward mental disorders which has prevailed throughout the ages. These conditions were thought to be inherited and thus incurable; hence, with the belief that the patient was hopelessly insane, it naturally followed that a certain stigma became attached to mental disease. This traditional attitude about mental illness greatly influenced the form of general management to which mental patients were subjected in the past.

Formerly it was not uncommon for the mentally ill to be tried as criminals and sentenced to death; similar ignorance and superstition produced the belief that they were possessed of demons, and often they were kept in chains in dark dungeons. It was not until a relatively short time ago that the mental patient was first regarded as a sick person who might deserve humane care and medical treatment. The geographical isolation of our present state hospitals for the mentally ill is an outgrowth of these ancient beliefs. Most of these hospitals are placed at the edge of a community completely removed from all normal activities and they are usually surrounded by large grounds further to insolate the inmates. The sole idea was to provide a place for custodial care where a person could be kept as economically as possible throughout the remainder of his life. There were no plans for treatment since no one entertained the idea that the mental patient could be restored to normal health.

It was not until some forty years ago that a real advance was made in the understanding and treatment of mental disease. A few intrepid physicians questioned the prevailing belief that mental disease was inherited, and they began to study the actions and expressions of patients to determine the underlying cause of such behavior. One of the greatest contributions to psychology and psychiatry was made by Dr. Sigmund Freud, who later developed the school of psychoanalysis. His studies showed that heredity played only a small part in the production of mental ill-

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ness. On the contrary, it was found that all human behavior, both normal and abnormal, could be explained on the basis of a person's day to day life experiences, and he emphasized the influence which early environment had on a child's personality development. A notable contemporary of Freud, Dr. Adolph Meyer, who is known popularly as "the father of American psychiatry," expressed the same viewpoint about the cause of mental illness. He believed that mental and nervous disorders resulted from acquired life experiences, but differed from Freud's belief by maintaining that the illness is a reaction to the total life experiences of the person and not merely a reaction to the early environment of the child.

These new concepts of mental disease signified that mental patients could recover and for the first time it held out definite hope that illnesses could be prevented as well as treated. These views influenced Mr. Clifford Beers, a recovered mental patient himself, to start a mental hygiene movement in this country during the early part of this century. The National Committee for Mental Hygiene was formed by this pioneer group and it has contributed more than any other single agency to the advances made in American psychiatry during the twentieth century.

This greater knowledge of the true nature of mental illness stimulated a new interest in psychiatry. An understanding of the causes of psychiatric conditions now enabled physicians to treat them, and mental illness assumed the same status in the field of medicine that is occupied by other illnesses which have a definite cause and cure. In addition to the existing custodial type of hospitals, other hospitals were erected to be devoted to the management of acute mental illnesses. Among the first constructed were the Henry Phipps Psychiatric Clinic in connection with Johns Hopkins Medical School and the State Psychopathic Hospital at the University of Michigan School of Medicine. Soon many other states began to erect psychopathic hospitals in conjunction with medical schools or else in large medical centers where the facilities of such hospitals could be utilized for teaching and training purposes. These hospitals permitted the mental patient to be removed from complete isolation and to be transferred to facilities where other types of patients were hospitalized.

Still later, as the general medical profession acquired a better understanding of psychiatry and a more hopeful attitude concerning recovery of the mental patient, general hospitals began to establish special facilities within their confines for the care and treatment of mentally sick patients. This movement gained more impetus during the early 1930's, for many hospitals were half empty at the time and welcomed this new source of revenue. Although in the beginning many such units were established for mercenary reasons, yet today most physicians believe that this is the ideal arrangement to take care of the mentally ill. Now both psychiatry and the psychiatric patient have been removed entirely from their former state of isolation. Physicians no longer consider mental illness as a disgrace and have come to regard psychiatric disorders in the same way that they conceive of medical and surgical conditions. Certainly the medical profession has gained from the establishment of psychiatric divisions in general hospitals, and it has many advantages for the patient. Foremost is the availability of medical and surgical consultants, laboratories for diagnostic study, and ready access to special treatment devices and facilities. The majority of hospital authorities now feel that most large general hospitals should have a division wherein acute mental patients can receive treatment. Once this is an accomplished fact, it will be unnecessary to send these patients over long distances to isolated private or state mental hospitals.

While on the subject of the psychiatric hospital, it is worth while to note the progress which has been made in psychiatric education. Whereas twenty years ago only four or five medical schools in this country provided an adequate course in psychiatric instruction, today nearly all class A medical schools are teaching psychiatry throughout the four years of the medical curriculum. In addition to undergraduate psychiatric teaching for medical students and student nurses, all recognized psychiatric hospitals give postgraduate training in psychiatry to interns and residents. Additional schools have been established for nurses, psychiatric social workers, and other allied personnel. The psychiatric unit in the general hospital is an ideal place for psychiatric training of these diversified groups, as it enables them to integrate their knowledge of human relationships and behavior into the whole field of general medicine. All medical educators recognize the vital role which the emotions exert on the general health of all patients. Thus the ideal method of teaching psychiatry is to allot the major portion of psychiatric instruction to the study of the personality functions and the minor psychiatric disorders, that is, the psychoneuroses. If this is done, the medical or nursing graduate will leave school with the point of view that he

has to treat the entire person and not merely the organ or bodily system of which the patient is complaining.

A psychoneurosis is such a common type of illness that it will justify some of our attention. It is perhaps the most frequently encountered of all diseases and constitutes 30 to 40 per cent of illnesses, both physical and mental. The recent war has attracted attention to this group of disorders, and everyone has seen references to this term in the daily press or in the popular magazines. A psychoneurosis is a condition which results from the effect of unhappiness, worry, or stress of any kind, and the person reacts by developing anxiety and tension which either produces a disturbance of physical function, a fear state, great anxiety, or a combination of these symptoms. The occurrence of physical symptoms is frequent in the person with a psychoneurosis. The psychoneuroses produce such varied symptoms as indigestion, constipation, fast beating of the heart, headache, backache, or other bodily pains, and, in fact, can duplicate almost any symptom which is caused by a physical disease. These symptoms often resemble those of well known organic diseases and it is sometimes difficult to distinguish between the two. The symptoms are genuine and actually exist as far as the patient is concerned; however, there is no disease of the physical structures, because the symptoms are psychological in origin and represent a reaction on the part of the patient to his total life situation and the existing stresses which are confronting him. Incidentally, no one is immune to the development of such an illness, provided the person is exposed to sufficiently severe stress producing situations.

Our knowledge of psychiatry has now progressed to the point where any well-informed physician can diagnose and treat a person with a psychoneurosis. Most patients with these minor nervous disorders can be treated by their own private physician and only in the more extreme or severe cases is it necessary for the patient to consult a psychiatrist. Usually this is not true of the major mental disorders, for they do require skilled care, which must be administered by a trained psychiatrist. However, the recent development of the various shock treatments make it possible to bring about a recovery even in the most disturbed and excited patients within a reasonably short period of time.

In summary, it must be realized that mental illness is not a disgrace; that the vast majority of acute mental disorders are curable and frequently with as little time and expense as a medical or surgical condition; that the psychoneuroses make up a very big part of general medicine; and that the physician of today and the future must be a psychiatrist to the extent that he can recognize a major mental disorder in order to refer the patient for early treatment to facilitate recovery. The physician should be able to recognize suicidal tendencies and provide adequate protection for the patient. He should be able to recognize the psychoneuroses and manage them properly. He should realize the significance of unhealthy and unhappy experiences which contribute to the development of nervous illness and in turn try to correct them. He should appreciate the significance of fear and anxiety and do all that he can to allay them. He should do everything possible to promote a wholesome, happy outlook in every patient under his care, and he should instruct parents about the emotional needs of children so that the child may develop a stable personality.

John Sealy Hospital.

WORLD WAR II MEDICAL HISTORY

A medical history of World War II has been planned in three parts, according to information released May 31 by the Surgeon General's office, following a meeting of the advisory editorial board. Part I will be devoted to the operation and administration of the medical department, including such topics as supply and fiscal activities, evacuation, personnel procedures and hospital construction. Part II will be designated for professional readers and will cover clinical and technical experience in medicine, surgery, psychiatry, preventive medicine, aviation medicine, physical medicine, dentistry, and veterinary medicine. Part III will consist of a series of medico-military monographs dealing with specialized subjects of interest primarily to officers of the regular Army, including effective utilization of specialists, standardization of supplies, and operation of the bed credit system. A popular summary of the medical department's work for the general public is also being considered.

THREE MILLION BIRTHS IN 1945

The more than three million babies born in the United States in 1945 reflect the continuing increase in the birth rate for the past several years. It is estimated that between 1933 and 1943 the birth rate increased 30 per cent, according to an editorial in the May 18 issue of *The Journal of the American Medical Association.*

Continuing the editorial says:

"This does not mean that the average American family is growing larger. The principal explanation for the increase appears to be the rise in the marriage rate and the increase of one and two child families. This is deducted from the analysis of the increase in the first, second, third and fourth or higher births in the family. Thus, during the war years 1941 to 1943 the birth rate for all women in the reproductive age increased 22 per cent; first births increased 21 per cent, second births 31 per cent, third births 27 per cent and fourth births 19.5 per cent."

MEDICAL OFFICERS RETURNING TO TEXAS*

(Corrections: Bruce Hay, listed at Wichita Falls, returned to Pecos.)

NAME	Serv.†	Location	Release Date
Anderson-Houston-Leon Counties			
3. Murphy, Joseph G.	A	Palestine	
4. Simms, Otho M.	A	Normangee	
Austin-Waller Counties			
3. Neely, Robert A.	N	Bellville	
Baylor-Knox-Haskell Counties			
4. Wiggins, James K.	N	Munday	
Bell County			
13. Brindley, Hanes H.	A	Temple	
14. Drewry, Lawrence E.	N	Temple	
15. Smith, Travis	N	Temple	
Bexar County			
97. Bosshardt, Carl E.	A	San Antonio	Jan., 1946
98. Burk, Joseph E.	A	San Antonio	
99. Fox, Kermit W.	A	San Antonio[1]	
100. Fried, Bernard H.	A	San Antonio	
101. Goetz, Joseph T.	N	San Antonio	
102. McComb, Asher R.	A	San Antonio	Apr., 1946
103. O'Neill, Francis E.	A	San Antonio	Apr., 1946
104. Schwartzberg, Samuel	A	San Antonio	
105. Siegel, Lawrence H.	A	San Antonio	
106. Stevenson, Roger	N	San Antonio	
107. Trevino, Saul S.	A	San Antonio	
108. Waldron, Wilbur D.	A	San Antonio	
109. Wiesner, William A.	A	San Antonio	
Brazoria County			
3. Nicholson, William D.	A	Freeport	Jan., 1946
Brazos-Robertson Counties			
4. Harrison, R. Henry	A	Bryan	Nov., 1945
5. Searcy, Roland M.	N	Bryan	
Brooks-Duval-Jim Wells Counties			
9. Gaston, Earl	N	Falfurrias	
Cameron-Willacy Counties			
12. Casey, James D.	N	San Benito	
Cass-Marion Counties			
3. Jenkins, Marion T.	N	Hughes Springs	
Cherokee County			
4. Scarborough, Lee F.	A	Rusk	
Collin County			
5. Johnson, James L.	A	McKinney[2]	
Dallas County			
147. Aldredge, George N., Jr.	A	Dallas	
148. Collier, Gates	N	Dallas	
149. Compere, Dolphus E.	A	Dallas	
150. Cooper, Jack C.	N	Dallas	
151. Deter, Russell L.	A	Dallas	
152. Gendel, Joseph	A	Dallas	
153. Gill, Horace E.	A	Dallas	
154. Harper, Jack C.	N	Dallas	
155. Hopkins, Jesse J.	A	Dallas	
156. Horn, J. Morris	A	Dallas[2]	June, 1946
157. Maxfield, G. S.	A	Dallas	
158. Muirhead, Ernest E.	N	Dallas	
159. Shields, Thomas L.	A	Dallas	
160. Smith, Sydnie G.	A	Dallas	
161. Stiles, Wendell A.	A	Dallas	
162. Stringer, Charles F.	N	Dallas	
Dawson-Lynn-Terry-Gaines-Yoakum Counties			
6. Gerardy, Carl W.	A	Seagraves	
Eastland-Callahan Counties			
3. Whittington, Jas. H. C.	N	Eastland	
Ector-Midland-Martin-Howard-Andrews-Glasscock Counties			
10. Koberg, Frederick J.	A	Big Spring	
El Paso County			
41. Hyslop, James R.	A	El Paso	
42. Robbins, Jacob B.	A	El Paso	
Erath-Hood-Somervell Counties			
3. Herndon, Charles H.	A	Dublin	
Falls County			
5. Allen, Walter B.		Marlin	
Galveston County			
42. Adriance, Carroll T.	A	Galveston	Apr., 1946
43. Casey, Robert E.	A	Galveston	
Grayson County			
10. Stafford, Frederick B.	N	Sherman[1]	
11. Tuck, Vernon L.	A	Sherman	Jan., 1946
Guadalupe County			
2. Knolle, Robert L., Jr.	N	Seguin	
Harris County			
203. Cowart, Edmund M.	A	Houston	
204. Crain, Lovell B.	A	Houston	
205. Delambre, Lorry C.	N	Houston	
206. Denham, Frank R.	N	Houston	
207. Donohue, William M.	A	Houston	
208. Evans, Howard L.	N	Houston	
209. Hill, Joel M.	N	Houston	Apr., 1946
210. Mood, George F.	N	Houston	
211. Much, Joseph C.	N	Houston	
212. Osmun, Paul M.	A	Houston	
213. Patella, Armand M.	N	Houston	
214. Scardino, Peter L.	N	Houston	
215. Schaffer, S. S.	A	Houston	
216. Stevenson, Murphy D.	N	Houston	
217. Tyner, Furman H.	A	Houston[2]	Apr., 1946
218. Williams, Edward C.	N	Houston	
219. Williams, William O.	A	Houston	
Harrison County			
7. Mondrick, Frank V.	A	Marshall	
Hidalgo-Starr Counties			
9. Evans, Robert W.	A	Edinburg	
Hopkins-Franklin Counties			
3. Wood, Joe B.	A	Sulphur Springs	
Hunt-Rockwall-Rains Counties			
11. Bush, William L.	A	Greenville[3]	Feb., 1946
Jefferson County			
43. Carter, Louian C.	A	Port Arthur	
44. Graber, D. W. J.		Beaumont	Mar., 1946
45. Jones, Thomas R.		Beaumont	Jan., 1946
46. Miller, Sidney	N	Port Arthur	
47. Sprott, Curtis B.	A	Beaumont	
48. Stephenson, G. Bruce	N	Beaumont	Apr., 1946
Kaufman County			
5. Brin, Alfred R.	A	Terrell	
Kleberg-Kenedy Counties			
4. Ewert, William A.	A	Kingsville	
Lamar County			
6. Nickerson, Samuel H.	A	Paris	
Liberty-Chambers Counties			
4. Lewellyn, John S.	N	Liberty	
Lubbock-Crosby Counties			
17. Donaldson. J. D., Jr.	N	Lubbock	
18. Douglas, R. C.	A	Lubbock	
19. Gibson, Hester M., Jr.	A	Lubbock	
McLennan County			
28. Coffelt, Ralph	N	Waco	
29. Gerlich, Norman A.	A	Waco	
30. Klatman, Sol	A	Waco	
Nolan-Fisher-Mitchell Counties			
7. Johnson, Dale F.	A	Loraine	Jan., 1946
8. Peavy, James E., Jr.	A	Sweetwater	
Nueces County			
26. Ashmore, Alvin J.	A	Corpus Christi	
27. Donahue, Francis D.	N	Corpus Christi	
28. Ford, Richard B.	N	Corpus Christi	
29. Gill, Earl K.	A	Corpus Christi	Mar., 1946
Potter County			
23. Goldston, Alton B.	A	Amarillo	
24. Hood, John G.	A	Amarillo	
25. Peterson, Edwin P.	A	Amarillo	
26. Puckett, Howard E.	A	Amarillo	July, 1946
27. Wertz, Royal F.	A	Amarillo	
Reeves-Ward-Winkler-Loving-Culberson-Hudspeth Counties			
5. Wright, Bennett A.	N	Kermit	

*EDITOR'S NOTE: This list is the ninth of a series in which it is hoped to name all those physicians who have been in the Armed Forces during the war just passed and have now returned to Texas to resume civilian practice. The information in this list has been assembled from a variety of sources. While an attempt has been made to secure as complete and as accurate data as possible, we are aware that omissions and errors have been made. Not only for publication in the JOURNAL but also for the permanent records in the central office of the State Medical Association, we invite and urge correction of and addition to the material here submitted. Note that physicians from each county area are numbered consecutively following those listed in the June JOURNAL; the last number in each section therefore indicates the total physicians returned to that county area. The complete total for Texas named to date (June 25), including the accompanying list, is 1,353.

†A=Army; N=Navy; U=U. S. Public Health Service.
[1]Formerly of Bryan.
[2]Formerly of Fort Worth.

[1]Formerly of Leonard.
[2]Formerly of Port Arthur.
[3]Formerly of San Angelo.

NAME	Serv.†	Location	Release Date
Runnels County			
2. Baker, David M.	N	Ballinger	
Smith County			
8. Birdwell, James W.	N	Tyler	
9. Goldfeder, Jesse	N	Tyler	
10. Vaughn, James M.	N	Tyler	
Tarrant County			
70. Harris, Charles H., II	A	Fort Worth	
71. Innis, Emart R.	N	Fort Worth	
72. Major, A. D.	A	Fort Worth	
73. Reeves, E. Edwin	N	Fort Worth[1]	Apr., 1946
74. Terrell, Charles J.	A	Fort Worth	
Taylor-Jones Counties			
18. Williams, William H., Jr.	A	Abilene	
19. Williamson, Lee	A	Abilene	
Tom Green-Coke-Crockett-Concho-Irion-Sterling-Sutton-Schleicher Counties			
12. Wright, John L., Jr.	A	San Angelo	
Travis County			
33. Bailey, Charles W.	A	Austin	
34. Blewett, Emerson K., Jr.	N	Austin	
35. Creel, Wylie F.	A	Austin	
36. Gilbert, Joe T.	A	Austin	
37. Hanes, Lisburn C., Jr.	A	Austin	
38. Rothen, Robert M.	A	Austin	
39. Wheelis, Allen B.	N	Austin	
40. Williams, Harold L.	N	Austin[1]	
Walker-Madison-Trinity Counties			
8. Eberle, Howard J.	N	Madisonville	
9. Garrett, John C.	A	Huntsville	
Wharton-Jackson-Matagorda-Fort Bend Counties			
9. Giddings, Harold D.	N	El Campo	
10. Matlage, William T., Jr.	N	Sugar Land	
Wichita County			
16. Brown, C. H.	A	Wichita Falls	
17. Lea, Austin W.	N	Wichita Falls	
18. Mein, Robert M.	A	Wichita Falls	
19. Nathan, Robert E.	A	Wichita Falls	
Young-Jack-Archer Counties			
6. Fillmore, Rollin S.	A	Jacksboro	
7. Lovett, Raymond E.	A	Olney	
8. Winstead, D. E.	A	Graham	

[1]Formerly of Amarillo.

[1]Formerly of Texarkana.

MISCELLANEOUS

COMING MEETINGS AND CLINICS

State Medical Association of Texas, Dallas, May 5-8, 1947. Dr. C. C. Cody, Jr., Houston, President; Dr. Holman Taylor, 1404 W. El Paso St., Fort Worth 3, Secretary.

American Medical Association, San Francisco, July 1-5, 1946. Dr. Roger I. Lee, Boston, President; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secretary.

Southern Medical Association, Miami, Fla., November 4-7, 1946. Dr. M. Y. Dabney, Birmingham, Ala., President; C. P. Loranz, Empire Building, Birmingham, Ala., Secretary-Manager.

Southwest Allergy Forum, Shreveport, La., April, 1947. Dr. W. H. Browning, Shreveport, La., President; Dr. Sim Hulsey, Medical Arts Bldg., Fort Worth, Secretary.

Texas Association of Medical Anesthetists, Dallas, May, 1947. Dr. Claudia Potter, Temple, President; Dr. Russell Bonham, Box 6237, Houston, Secretary.

Texas Association of Obstetricians and Gynecologists, Galveston. Dr. Allen McMurrey, Houston, President; Dr. Julius McIver, 714 Medical Arts Building, Dallas, Secretary.

Texas Chapter, American College of Chest Physicians. Dr. R. G. McCorkle, San Antonio, President; Dr. Elliott Mendenhall, 1217 Medical Arts Bldg., Dallas, Secretary.

Texas Club of Internists. Dr. Robert M. Barton, Dallas, President; Dr. Julian C. Barton, 414 Navarro St., San Antonio, Secretary.

Texas Hospital Association, Houston, March 27-29, 1947. Tol Terrell, Harris Memorial Methodist Hospital, Fort Worth, President; Mrs. Ruth Barnhart, 720 College Ave., Dallas, Secretary.

Texas Neuropsychiatric Association, Dallas, May, 1947. Dr. Fred T. Rogers, Dallas, President; Dr. David Wade, 604 Capital National Bank Bldg., Austin, Secretary.

Texas Ophthalmological and Otolaryngological Society, Dallas, December, 1946. Dr. C. B. Williams, Mineral Wells, President; Dr. E. D. Dumas, 425 Medical Arts Bldg., San Antonio, Secretary.

Texas Orthopedic Society. Dr. E. A. Cayo, San Antonio, President; Dr. Edward Smith, 1215 Walker Ave., Houston, Secretary.

Texas Pediatric Society, Fort Worth, October, 1946. Dr. Max Woodward, Sherman, President; Dr. John E. Ashby, 3610 Fairmount, Dallas, Secretary.

Texas Public Health Association, Dallas. Dr. L. P. Walter, Austin, President; Mr. Earle W. Sudderth, Dallas County Health Department, Court House, Dallas, Secretary.

Texas Radiological Society, January, 1947. Dr. Herman Klapproth, Sherman, President; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secretary.

Texas Railway and Traumatic Surgical Association. Dr. F. L. Snyder, Fort Worth, President; Dr. Ross Trigg, First National Bank Bldg., Fort Worth, Secretary.

Texas Society for Mental Hygiene. Dr. Jack R. Ewalt, University of Texas Medical Branch, Galveston, President; Mrs. Elizabeth F. Gardner, 1617 Watchhill Road, Austin 21, Executive Secretary.

Texas Society of Gastro-Enterologists and Proctologists, Dallas, May, 1947. Dr. Tom E. Smith, Dallas, President; Dr. D. L. Curb, 704 Dallas Ave., Houston, Secretary.

Texas Society of Pathologists, Houston, January, 1947. Dr. May Owen, Fort Worth, President; Dr. C. T. Ashworth, Southwestern Medical College, Dallas, Secretary.

Texas State Heart Association, Dallas, May, 1947. Dr. Robert M. Barton, Dallas, President; Dr. M. B. Whitten, Medical Arts Bldg., Dallas, Secretary.

Texas Surgical Society, Houston, October 7-8, 1946. Dr. G. V. Brindley, Temple, President; Dr. Walter Stuck, 1426 Nix Professional Building, San Antonio, Secretary.

Texas Tuberculosis Association, Houston, September 16-17, 1946. Dr. J. B. White, Amarillo, President; Miss Pansy Nichols, 700 Brazos, Austin, Executive Secretary.

Third Panhandle, District Medical Society, Lubbock, October 8-9, 1946. Dr. W. A. Carroll, Claude, President; Dr. George Powers, Fisk Bldg., Amarillo, Secretary.

Fourth District Medical Society, Brady, November, 1946. Dr. H. L. Locker, Brownwood, President; Dr. Glenn H. Ricks, Brady, Secretary.

Seventh, Austin, District Society, Austin, July, 1946. Dr. Robert B. Morrison, Austin, President; Dr. M. I. Brown, Capital National Bank Bldg., Austin, Secretary.

Eighth, Ninth and Tenth Districts Medical Society, Orange, April, 1947. Dr. Walter F. Hasskarl, Brenham, President; Dr. George W. Waldron, Medical Arts Bldg., Houston, Secretary.

Eleventh District Society, Palestine, October, 1946. Dr. L. L. Travis, Jacksonville, President; Dr. C. B. Young, 929 S. Confederate, Tyler, Secretary.

Twelfth, Central Texas District Society, Corsicana, July 9, 1946. Dr. Thomas G. Glass, Marlin, President; Dr. H. F. Connally, Jr., Amicable Bldg., Waco, Secretary.

Thirteenth, Northwest District Society. Dr. A. L. Roberts, Fort Worth President; Dr. Joe R. Wise, 1212 W. Lancaster, Fort Worth, Secretary.

Fourteenth District Society. Dr. C. B. Thayer, Gainesville, President; Dr. V. L. Tuck, Sherman, Secretary.

Fifteenth, Northeast Texas, District Society, October, 1946. Dr. Frank Littlejohn Marshall, President; Dr. Henry H. Neihuss, Greggton, Secretary.

CLINICS

Dallas Southern Clinical Conference, Dallas, March 17-20, 1947. Miss Thelma J. Webb, 1133 Medical Arts Bldg., Dallas 1, Executive Secretary.

Post Graduate Medical Assembly of South Texas, Houston, December 3-5, 1946. Secretary, 229 Medical Arts Building, Houston.

SMALLPOX DECLINES

Smallpox reached its lowest ebb in the United States in 1945, according to statisticians of the Metropolitan Life Insurance Company. Last year only 346 cases were reported in the entire country, and thirteen states on the Atlantic Seaboard and the District of Columbia were completely free of the disease. In Canada only 5 cases were reported. As recently as 1930, 48,920 cases were reported in the United States.

HOSPITALS NEEDING INTERNS AND RESIDENTS

Methodist Hospital, Dallas. Capacity 206 beds. C. B. Fielder, Superintendent; (2 interns now).

El Paso City County Hospital, El Paso. Capacity 192 beds. George W. Cook, Col., U. S. A., Ret., Superintendent; (3 interns for one year term, graduates of class A medical school only).

ASSOCIATED MEDICAL CARE PLANS

Voluntary medical care plans in nine states have been admitted so far to membership in Associated Medical Care Plans, a new national nonprofit organization which will include all state and local medical care plans that comply with the minimum standards approved by the Council on Medical Service and Public Relations of the American Medical Association.

According to the May 18 issue of *The Journal of the American Medical Association,* the nine plans which have been tentatively approved as meeting the standards of the Council are: California Physicians' Service, Iowa Medical Service, Michigan Medical Service, Ohio Medical Indemnity, Oregon Physicians' Service, Medical Service Association of Pennsylvania, Medical-Surgical Plan of New Jersey, Nebraska Surgical Plan and Surgical Care, Inc., of Kansas City, Mo.

The nine applications will be formally presented for acceptance at the May 17 meeting of the Council, and additional applications will be considered at the June 28 meeting.

The Journal says that Council members are busy preparing an interpretation of the "Standards of Approval" as they will be used in granting the "Seal of Acceptance." Under certain conditions, the Council will grant the right to print its seal on all official papers of accepted plans and on any promotional literature or display material used by these plans.

"Suggestions as to the type of seal that might be used have been received from various sources," *The Journal* says, "and will be acted on by the executive committee of the Council this month. The favorite to date is a shield outlined in blue, with a caduceus in the center." Continuing, *The Journal* says in part:

"Thirty-one states now have voluntary prepayment medical care plans. These are Alabama, California, Colorado, Connecticut, Delaware, Florida, Indiana, Iowa, Kansas, Louisiana, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Jersey, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Texas, Utah, Virginia, Washington, West Virginia and Wisconsin.

"Seventy-three plans are included in the 31 states named. However, for tabulation purposes the 20 Washington state bureaus and the five Oregon plans might better be set forth as two statewide plans, thus reducing the quoted total to 51 plans. Twenty-three states have only one plan, in most cases statewide. Four states have two plans each, a statewide plus a local plan, or two plans dividing the state. Three states have three plans. One state has five plans and one state has six plans. Thirty-four of the plans operate in coördination with Blue Cross Plans.

"The 10 medical plans launched in 1945 are the Alabama Hospital Service Association (by rider), Iowa Medical Service, Hospital Service of New Orleans (by rider), Missouri Medical Service (St. Louis), Nebraska Surgical Plan, Central New York Medical Plan, Inc. (Syracuse), Medical Mutual of Cleveland, Oklahoma Physicians' Service, Group Medical & Surgical Service (Dallas, Texas), and Surgical Care, Inc. (Roanoke, Va.).

"The 10 plans that have been set up thus far in 1946 are Connecticut Medical Service, Florida Medical Service Corp., Mutual Medical Service, Inc., of Indiana, Kansas Physicians' Service, Montana Physicians' Service, New Mexico Physicians' Service, Northeastern New York Medical Service, Inc. (Albany), Ohio Medical Indemnity Medical Service Bureau of the Utah Medical Association, Inc., and the Wisconsin State Association Plan.

"In eight additional states and the District of Columbia plans are in process of formation: Arizona, Idaho, Illinois, Maine, Maryland, Minnesota, Rhode Island and Wyoming."

OBSTETRICS AND GYNECOLOGY BOARD

The American Board of Obstetrics and Gynecology, at its annual meeting in Chicago in May, certified 141 candidates, the secretary reports.

Among changes in regulations put into effect are that case records must be forwarded to the secretary's office from thirty to sixty days after the candidate has received notice of his eligibility for admission to the examinations for certification, and that nine months residency will not be accepted as an academic year toward years of training requirements following the termination of the official period of intern and residency acceleration, April 1, 1946.

The next written examination (Part I) will be held February 7, 1947. Applications will be received until November 1, 1946.

EDUCATION FOR BETTER SIGHT

A new series of messages designed to correct the public's misconception concerning the true relation of glasses to eye comfort and visual efficiency will be carried in magazines of national distribution by the American Optical Company during 1946. The current educational program is designed exclusively to advance professional eye care and does not advertise focused ophthalmic products to the public. The series will illustrate the absurdity of health superstitions and the misconception that glasses alone can correct faulty vision.

A. M. A. COUNCIL REPORTS

COUNCIL ON PHARMACY AND CHEMISTRY

NEW AND NONOFFICIAL REMEDIES

The following articles have been accepted as conforming to the rules of the Council on Pharmacy and Chemistry of the American Medical Association for admission to New and Nonofficial Remedies. A copy of the rules on which the Council bases its action will be sent on application.

AUSTIN SMITH, M. D., *Secretary.*

Diethylstilbestrol Dipropionate.—The *di*-propionyl ester of *α,α'*-diethyl-4,4'-stilbenediol.—$C_{24}H_{28}O$—M. W. 380.46.—Diethylstilbestrol dipropionate may be prepared by esterification of diethylstilbestrol with propionic acid chloride and purified by recrystallization from alcohol.

Actions and Uses.—Diethylstilbestrol dipropionate is used for the same conditions for which estrogenic substances are employed, although it is claimed that reactions such as nausea and vomiting appear to be less frequent with a dipropionate salt than with free diethylstilbestrol when the drugs are administered intramuscularly in oil. Diethylstilbestrol dipropionate is relatively slowly absorbed from the oil depot and causes a lower blood stream concentration, although one of more prolonged duration.

Dosage.—Diethylstilbestrol Dipropionate in Oil is administered intramuscularly. The following average dosage by injection should be modified to meet individual requirements:

Senile vaginitis } from 0.5 to 2 mg. two or three
Menopause } times a week.

Suppression of lactation—5 mg. once or twice daily for a total of from two to four days.

After a therapeutic effect has been obtained, the dosage should be reduced until the minimum effective dose for maintenance has been established.

The following dosage form has been accepted:
WINTHROP CHEMICAL COMPANY, INC., NEW YORK
Solution Diethylstilbestrol Dipropionate (in Olive Oil): 0.5 mg. per cc., 1 mg. per cc. and 5 mg. per cc.; 1 cc. ampuls.

Hexavitamin (See J. A. M. A., Aug. 11, 1945, p. 1099).

The following dosage form has been accepted:
WALKER VITAMIN PRODUCTS, INC., MOUNT VERNON, N. Y.
Capsules Hexavitamin: Each capsule contains 2,500 U. S. P. units of vitamin A, 200 U. S. P. units of vitamin D, 1 mg. of thiamine, 1.5 mg. of riboflavin, 30 mg. of ascorbic acid and 10 mg. of niacinamide.
— J. A. M. A., March 30, 1946.

Mercuhydrin Sodium Solution.—Meralluride Sodium Solution.—A sterile aqueous solution containing in each cubic centimeter approximately 119 mg. of mercuhydrin and 13 mg. of theophylline, adjusted with sodium hydroxide to a *p*H of about 7.5. Each 1 cc. of mercuhydrin sodium solution contains the equivalent of 39 mg. of mercury and 48 mg. of theophylline-U. S. P.

Actions and Uses.—Mercuhydrin Sodium Solution is a mercurial diuretic claimed to be indicated in the edema of cardiorenal disease and of nephrosis, ascites of liver disease and other conditions in which a mercurial diuretic may be proposed.

It is claimed to be well tolerated systemically and significantly free from reaction at the site of injection when given intramuscularly. It is rapidly absorbed following intramuscular injection. It also is administered by intravenous injection.

The drug is contraindicated in acute nephritis and chronic kidney disease in which well defined tubular and glomerular changes are present. Since mercury is known to give rise in sensitive patients to side effects such as stomatitis, gastric disturbance, vertigo, febrile reaction and cutaneous eruptions, it is suggested that initial tests and careful regulation of dosage be followed when mercurial diuretics are used. During prolonged administration the urine should be examined periodically for albumin casts and blood cells.

Dosage.—Depending on the condition of the patient and route and the frequency of administration, the usual dose of Mercuhydrin Sodium Solution is from 1 cc. to 2 cc. In view of occasional cases of idiosyncrasy to mercurials, the initial dose could be 0.5 cc. or less. Subsequent injections may be given twice weekly, as indicated by the condition of the patient. One investigator has recommended smaller doses repeated at shorter intervals and emphasizes the importance of observing daily water balance instead of weekly observations.

LAKESIDE LABORATORIES, INC., MILWAUKEE
Solution Mercuhydrin Sodium: 1 cc. and 2 cc. ampuls.

Mannitol Hexanitrate (See New and Nonofficial Remedies, 1945, p. 334).

The following dosage form has been accepted:
WILLIAM H. RORER, INC., PHILADELPHIA
Tablets Mannitol Hexanitrate: 32 mg.

Penicillin (See New and Nonofficial Remedies, 1945, p. 214).

The following additional dosage form has been accepted:
ABBOTT LABORATORIES, NORTH CHICAGO, ILL.
Penicillin Sodium Salt: 200,000 Oxford Unit vials.
—J. A. M. A., April 6, 1946.

Tuamine. — Racemic 2-aminoheptane. — Racemic *B*-aminoheptane.—$C_7H_{17}N$.—M. W. 115.22. The structural formula of 2-aminoheptane is:

$$\begin{array}{ccccccccc} & H & & H & & H & & H & & H \\ H_3C- & C & - & C & - & C & - & C & - & CH_3 \\ & H & & H & & H & & H & & NH_2 \end{array}$$

Actions and Uses.—Tuamine produces vasoconstrictive action and is a member of the group of compounds known as sympathomimetic amines. Inhalation of the vapors provides an effective method of treatment for acute rhinologic conditions and is of added usefulness when prolonged and repeated medication is necessary *(see also general monograph on sympathomimetic amines)*. It should be used with caution by those who have cardiovascular disease. It is made available in an "inhaler" type of device.

Dosage.—One or two gentle inhalations through each nostril, repeated at hourly intervals if needed.

ELI LILLY & CO., INDIANAPOLIS
Tuamine Inhaler: Each inhaler contains at the time of packing 2-aminoheptane carbonate, equivalent to 325 mg. of 2-aminoheptane, menthol, 32 mg. and ylang ylang oil, 65 mg.

Ephedrine Hydrochloride (See New and Nonofficial Remedies, 1945, p. 283).

The following additional dosage form has been accepted:
ABBOTT LABORATORIES, NORTH CHICAGO, ILL.
Solution Ephedrine Hydrochloride 5% and Procaine Hydrochloride 1%: 2 cc. ampuls.
—J. A. M. A., April 20, 1946.

Tuamine Sulfate. — 2-aminoheptane sulfate. — $C_{14}H_{36}O_4N_2S$.—M. W. 328.51.

The formula of 2-aminoheptane sulfate is:

$$(H_3CCH_2CH_2CH_2CH_2\underset{\underset{NH_2}{|}}{C}HCH_3)_2.H_2SO_4$$

Actions and Uses.—A 1 per cent solution of this compound exceeds the vasoconstrictive effects of a similar concentration of ephedrine, while 0.5 per cent has been found to produce about equal vasoconstrictor action. The duration of effect, when compared to that of ephedrine, is prolonged.

Dosage.—A 1 per cent solution may be applied to the mucous membranes of infants and adults by spray, dropper or tampon and is usually adequate for routine treatment. A 2 per cent solution, best applied by pledgets of cotton, may be used for operative procedures, diagnostic examination and to meet other special circumstances. For displacement therapy, a 0.2 per cent solution can be used.

ELI LILLY & CO., INDIANAPOLIS
Solution Tuamine Sulfate, 1%: 30 cc. and 475 cc. bottles. Each 100 cc. contains tuamine sulfate 1.0 Gm., potassium phosphate monobasic 0.68 Gm., sodium chloride 90 mg., methyl parahydroxybenzoate 26 mg. and propyl parahydroxybenzoate 14 mg.

Solution Tuamine Sulfate, 2%: 60 cc. and 475 cc. Each 100 cc. contains tuamine sulfate 2.0 Gm., potassium phosphate monobasic 0.68 Gm., methyl parahydroxybenzoate 26 mg. and propyl parahydroxybenzoate 14 mg.
—J. A. M. A., May 11, 1946.

LIBRARY NOTES

The package library consists of collections of reprints and other periodical material on various subjects, prepared for lending to members of the Association. Requests for packages should be addressed "Library, State Medical Association of Texas, 1404 W. El Paso Street, Fort Worth, Texas." Twenty-five cents in stamps should be enclosed with the request to cover postage and part of the expense of collecting the material. Only one package may be borrowed at a time, and packages are allowed to remain in the hands of the borrower for 14 days.

PACKAGE SERVICE

Packages were mailed from the Library of the State Medical Association during June, to the following:

Dr. H. J. Childress, Gilmer—*Spastic Paralysis, therapy* (8 articles).

Mr. Phil Fox, Dallas—*Licensure, Medical* (5 articles).

Dr. T. J. Williamson, Big Spring—(1 journal).

Dr. Perry R. Jeter, Childress—*Headache* (17 articles); *Typhus* (11 articles).

Dr. F. J. L. Blasingame, Wharton—*Blood, phosphatase* (11 articles); *Blood, potassium and Blood, sodium* (11 articles); *Blood, amylase* (10 articles).

Dr. Fred Harrell, Olney—*Testes, undescended* (13 articles).

Dr. W. P. Watkins, Eastland—*Pregnancy, diagnosis* (9 articles).

Dr. George Y. Swickard, Orange—*Blood Pressure, High, therapy* (12 articles).

Dr. Joe Kopecky, San Antonio—*Shoulder, pain* (7 articles).

Dr. I. H. Reddinger, Fort Worth—*Undulant Fever, therapy* (10 articles).

Dr. John T. Richards, Rockdale—*Pneumonia (virus)* (31 articles).

Dr. S. L. Blum, Beaumont—*Poliomyelitis, therapy* (18 articles).

Dr. John D. Gleckler, Denison—*Pregnancy, diagnosis* (2 articles).

Mr. Floyd G. Betts, Wharton—*Hospitals, organization and administration* (16 articles).

Dr. H. D. Patton, Hempstead—*Penicillin* (30 articles).

Dr. W. M. Rogers, Rule—*Claudication, intermittent* (10 articles).

Dr. L. R. Byrd, Jr., Port Arthur—*Lungs, edema* (14 articles); *Pneumothorax* (10 articles).

Dr. J. R. Nicholson, San Antonio—*Granuloma, inguinale* (20 articles).

Dr. Rogers Pierson, Beaumont—*Blood, groups* (22 articles).

Dr. Wallace Byrd, Wharton—(14 journals).

Dr. W. F. McKinley, Jr., Marlin—*Blood Sugar, hypoglycemia* (21 articles).

Dr. L. B. Woods, Lubbock—*Vertigo, aural* (13 articles).

Dr. O. W. Lowry, Gatesville—*Granulocytopenia* (24 articles).

Dr. Fred L. Story, Ennis—*Intestines, obstruction* (13 articles).

Dr. V. E. Friedewald, Big Spring—*Pollen* (16 articles).

Dr. E. W. Jones, Wellington—*Death, sudden* (20 articles).

Dr. R. L. Powers, San Angelo—*Blood, groups* (27 articles).

Dr. Earl Gaston, Falfurrias—*Hospitals, plans* (16 articles).

Providence Hospital, Waco—*Parkinsonism* (13 articles); *Varicose Veins, therapy* (11 articles); *Skin, transplantation* (5 articles); *Surgery* (1 journal); *Nurses and Nursing* (4 articles).

Dr. Charles H. Brown, Wichita Falls—*Vertigo, aural* (11 articles); *Nerves, acoustic* (10 articles).

Dr. Samuel W. Leslie, Toronto, Canada (1 journal).

Dr. F. T. McIntire, San Angelo—(2 journals).

Dr. Landon C. Arnim, Corpus Christi—*Hair, excessive* (15 articles).

Dr. J. S. Stanley, Matador—*Paralysis, therapy* (7 articles).

Dr. S. A. Alexander, Dallas—*Diabetes Mellitus, Pregnancy and diabetes* (23 articles).

Dr. James N. White, San Angelo—*Lungs, cancer* (5 articles).

Dr. Dalton Richardson, Austin—(1 journal).

Dr. J. J. Hanna, Glen Rose—*Relapsing Fever* (16 articles).

Dr. J. Weldon Carter, Palestine—*Varicose Veins* (22 articles).

Anonymous, Taylor—*Blood, sedimentation* (21 articles); (1 book); *Hematocrit* (6 articles).

Dr. J. D. Magee, Abilene—*Orbit, tumors* (10 articles).

Dr. Ray G. Boster, Sanatorium—*Coccidioidomycosis* (40 articles).

Dr. J. S. Stover, Truscott—*Demerol* (15 articles).

Dr. H. A. Mahaffey, Hillsboro—*Pneumonia (virus)* (26 articles).

Dr. Ernestine Smith, Amarillo—*Fluorides* (15 articles).

Dr. C. E. Adams, Abilene—*Uterus, hydatiform mole* (12 articles).

Dr. C. A. Mims, Mission—*Ulcers* (13 articles).

Dr. Ernest E. Miller, Beeville—*Carbon Monoxide, toxicity* (10 articles); *Mental Diseases, heredity* (7 articles).

Dr. R. W. Varner, Abilene—(1 journal).

Dr. Stanley L. Clayton, Hallettsville (1 journal).

Dr. J. W. Neely, Pecos—*Blood, groups* (17 articles).

Dr. R. G. Granberry, Marshall—(1 journal).

Dr. George M. Tulloch, Okmulgee, Okla.—28 journals); (2 packages).

Dr. T. D. Young, Roscoe—*Relapsing Fever* (18 articles).

Dr. J. H. Grammer, Fort Worth—*Addison's Disease* (43 articles).

Dr. Charles Mims, Missions—*Otitis Media* (14 articles).

Accessions

New York, The Macmillan Company—Davis: Through the Stratosphere; Cutler and Zollinger: Atlas of Surgical Operations.

Chicago, Cloud, Inc.—McCord: A Blind Hog's Acorns, Vignettes of the Maladies of Workers.

St. Louis, C. V. Mosby Company—John: Diabetes.

Philadelphia, W. B. Saunders Company—Curtis: Textbook of Gynecology, ed. 5; Andrews: Diseases of the Skin, ed. 3; Baetjer: Women in Industry.

New York, Philosophical Library—Hesse: Narcotic and Drug Addiction.

Springfield, Charles C. Thomas—Collens and Boas: The Modern Treatment of Diabetes Mellitus.

Philadelphia, The Blakiston Company—Elwyn: Diseases of the Retina.

Chicago, Modern Hospital Publishing Company—The Modern Small Hospital and Community Health Center.

Chicago: Year Book Publishers—Cullen: Anesthesia in General Practice.

Summary

Reprints received, 406.	Local users, 37.
Journals received, 204.	Borrowers by mail, 56.
Items consulted, 210.	Packages mailed, 69.
Items taken out, 173.	Items mailed, 920.

Total items consulted and mailed, 1,313.

MOTION PICTURE LENDING LIBRARY

Motion picture films on medical subjects, 16 mm., both silent and sound, some in color, and suitable for either medical or lay audiences, are available for loan to county medical societies, hospital staffs, or individual physicians, on request. Borrowers will be required to pay only the cost of shipment of the films, by express, with insurance, and for any damage to films while in the hands of the borrower.

Requests for films should be addressed to "Motion Picture Lending Library, State Medical Association of Texas, 1404 West El Paso Street, Fort Worth 3, Texas." A list of available films, with descriptions, will be furnished on request.

The following motion picture films were loaned by the Motion Picture Lending Library of the State Medical Association during June:

Choose to Live (Available through the courtesy of the U. S. Public Health Service and the American Society for the Control of Cancer)—Texas Christian University Sociology Class, Fort Worth.

Eyes for Tomorrow (Available through the courtesy of the Hurst Eye, Ear, Nose and Throat Hospital-

Clinic, Longview)—Medical Branch of the University of Texas, Galveston.

From Moo to You (Available through the courtesy of the Borden Company, New York)—Bethlehem Center for Negroes, Fort Worth, and the Medical Branch of the University of Texas, Galveston.

Immunization (Available through the courtesy of Lederle Laboratories, Inc., New York)—Medical Branch of the University of Texas, Galveston.

Infantile Paralysis, Your Fight Against (Available through the courtesy of the National Foundation for Infantile Paralysis, Inc.)—Rotary, Lions, and ABC Clubs, Negro and Mexican churches, Lamesa, and the Six-County Medical Society, Midland.

Know for Sure (Available through the courtesy of the Texas State Board of Health)—Texas Christian University Sociology Class, Fort Worth.

Normal Delivery (Available through the courtesy of Mead Johnson & Company, Evansville, Ind.)—Health Department Staff, Fort Worth.

Poliomyelitis, Sister Kenny Method of Treatment of (Available through the courtesy of Dr. Herbert Hipps, Waco)—Six-County Medical Society, Midland.

Routine x-rays of patients, nurses, and other hospital employees will not only disclose unsuspected tuberculosis which is extremely important to the individual but will also protect other patients and employees from the danger of infection. As more and more states are making tuberculosis a compensable disease, this factor will become increasingly important to hospital administration.—Karl H. Pfuetze, M. D., Med. Dir. and Supt., Mineral Springs San., Cannon Falls, Minn.

NEWS

Contributions to this department will be appreciated. News should be of general medical interest, such as public health activities, new hospitals, personal items of more than local value, etc. News for a particular number of the JOURNAL should be in the hands of the Editor not later than the fifteenth of the preceding month.

The Life Insurance Medical Research Fund has announced approval of nine fellowships and eleven new grants to institutions for research in diseases of the heart and arteries. Of these awards, three have been made in Texas: The University of Texas School of Medicine, Galveston, with Dr. A. N. Taylor in charge of the research received a grant, and Gus G. Casten and George T. Shires, students at Southwestern Medical College, Dallas, are recipients of student fellowships. The fund began operation only last fall, but the new grants and awards bring to $621,000 the allocations already made for research. The fellowships announced at this time are the first to be awarded. Fellowships on both postgraduate and undergraduate levels are open to residents of the United States and Canada, and it is anticipated that additional fellowships will be awarded later this year. The Fund, supported by 149 legal reserve life insurance companies in the United States and Canada, on July 1 established offices at the New York Academy of Medicine in New York City.

Debate Topic Is Medical Care.—Next year high schools and colleges throughout the nation will use as their debate topic, "*Resolved:* That the federal government should provide a system of complete medical care available to all citizens at public expense." The proposition was chosen in a nationwide referendum of debating leagues out of more than eight topics submitted by high school and college students and teachers, and was recently announced by the Committee on Debate Materials and Interstate Coöperation of the National University Extension Association, according to *The Journal of the American Medical Association.*

The American Book Center for War Devastated Libraries, Inc., has been formed to assist in rebuilding devastated libraries of war areas, *The Journal of the American Medical Association* reports. It is collecting and shipping abroad scholarly books and periodicals which will be useful in research and necessary in the physical, economic, social, and industrial rehabilitation and reconstruction of Europe and the Far East. The center cannot purchase books and periodicals; it must depend on gifts. Anyone wishing to coöperate should ship donations to the American Book Center, c/o Library of Congress, Washington 25, D. C. All shipments should be sent prepaid.

The Texas Tuberculosis Association sponsored an institute for lay workers in Austin May 13-17. An annual project, according to the Austin *American-Statesman*, the school this year included among its faculty Harold McGee, director of rehabilitation of the Virginia Tuberculosis Association; Glenn V. Armstrong, executive secretary of the Los Angeles County (Calif.) Tuberculosis and Health Association; Robert C. Patterson, Ph. D., executive secretary of the Ohio Tuberculosis Association, Columbus; Dr. Howard E. Smith, Texas State Health Department, Austin; Dr. Carl A. Nau, University of Texas School of Medicine, Galveston; Dr. David M. Gould, U. S. Public Health Service, Dallas; Dr. James E. Dailey, Houston; and Paul Bolton and Jim Turner, radio station KTBC, Austin.

Alpha Epsilon Delta, honorary premedical fraternity, held its annual statewide meeting at the University of Texas, Austin, on June 1. The fraternity reported 130 students and educators from seven schools in attendance. The program featured an afternoon lecture by Alfred Taylor, Ph. D., research biologist of the Clayton Biochemical Institute at the University, on "The Present Status of the Virus Concept in Cancer Research" and a demonstration and lecture on the electron microscope by L. L. Antes, Ph. D., member of the University of Texas engineering staff. D. Bailey Calvin, Ph. D., associate dean of the Medical Branch of the University, was toastmaster at a banquet at which Sol Haberman, Ph. D., of the Buchanan Blood Center, Dallas, spoke on the Rh factor and D. B. Klein, Ph. D., professor of psychology at the University, discussed "The Human Element in Medicine."

The Dallas Academy of Ophthalmology and Otolarygology elected officers June 5, choosing Dr. Speight Jenkins as president, Dr. Claude Winborn as vice-president, and Dr. E. L. Darrough as secretary-treasurer. All the new officers reside in Dallas. Dr. Earl Jackson, Fort Worth, and Dr. James W. Ward, Greenville, presented a symposium on eye, ear, nose, and throat hemorrhages. Dr. C. H. Brooks, Waco, and Dr. John V. Goode, Dallas, also spoke. Dr. Tom Barr, Dallas, retiring president, was honored at the meeting, reports the Dallas *Times-Herald.*

The School of Aviation Medicine at Randolph Field will continue its research into the problems of peacetime flying as part of the Army Air Forces new university system, the War Department has announced, according to the San Antonio *Express.* The results of the school's wartime work were praised in the announcement, which pointed out that thousands of flight surgeons, flight nurses, and medical technicians received training in such specialized fields as the effects of high altitude flying, methods of combating air sickness, reaction of the brain to air pressure, the suitability of various diets for flying, means of protection against the constant noise of aircraft operation, and the psychology of flying, all of which will mean greater protection

and greater comfort in civilian as well as military aviation.

A Beaumont Crippled Children's Clinic was held May 23 with Dr. Bruce Stephenson, Beaumont, and Drs. Edgar S. Ezell, G. W. N. Eggers, J. L. Walker, and William H. Ainsworth, University of Texas School of Medicine, Galveston, making the examinations. The clinic, which the Beaumont *Journal* reports attracted many children and their parents not only from Beaumont but from outlying areas, including Louisiana, was sponsored by the Junior League, whose members assisted with registration and transportation. The clinic was held primarily to determine which crippled children are eligible for state aid.

Medical Service Society projects for Texas, announced at the national meeting of the organization of pharmaceutical representatives in Dallas May 24-25, include a $500,000 Dallas Academy of Medicine building to be erected adjacent to Southwestern Medical College, establishment of a $45,000 hospital to treat poliomyelitis in East Texas, a crippled children's hospital for Fort Worth, a blood bank in Houston, and assistance in nurses' training at Wichita Falls, the Dallas *News* reports. The society, first organized in Dallas two years ago, has chapters throughout Texas and Oklahoma, and the projects named are being sponsored by the local chapters. Approximately one hundred members were present this year for the convention, which will be held at Oklahoma City in 1947. The Dallas Academy of Medicine plans, already in blueprint stage, call for an auditorium adequate for medical conventions, permanent exhibit space, a medical library for 10,000 books, a visual education room, and a cafeteria. The Academy will work closely with Southwestern Medical Foundation, which has already voiced approval of the project, and the board of directors will include representatives of the Dallas County Medical Society, Dallas Southern Clinical Society, Dallas County Pharmaceutical Association, Hospital Council, Dallas County Dental Society, Dental Assistants, and Nurses Associations.

A Shortage of Nurses has become sufficiently acute that the Texas League of Nursing Education working with the Texas Hospital Association invited representatives from the State Medical Association, Texas Graduate Nurses Association, State Organization for Public Health Nursing, and Texas State Board of Nurse Examiners to meet with them in Dallas on June 19 to discuss a campaign to recruit student nurses. Dr. Everett C. Fox, president of Dallas County Medical Society, upon appointment by Dr. C. C. Cody, Jr., President of the State Medical Association, represented that organization at the Dallas meeting.

Reports from the meeting are that the group recommended employment of a public relations expert for three months, if funds for the purpose can be raised, to direct a publicity program aimed toward increasing appreciably the number of prospective nurses who will enroll for training in the fall. The necessity for such a venture was urged by submission of figures indicating that student admissions for the thirty-seven Texas schools of nursing in the spring were only 300 in 1946 as compared with 1,081 in 1941, 1,443 in 1944, and 1,137 in 1945, despite the fact that many vacancies for graduate nurses now exist. The Texas Hospital Association agreed to try to raise the money for a publicity campaign by asking for donations from Texas hospitals.

The support of physicians was requested particularly in telling qualified persons of the need for and opportunities available to graduate nurses.

Southwestern Medical College presented doctor of medicine degrees to thirty-four students on June 10, marking the fourth such commencement of the college and the first graduating class to receive its entire instruction at Southwestern, informs the Dallas *News*. Dr. H. H. Shoulders, Nashville, Tenn., who assumed the presidency of the American Medical Association on July 2, was the speaker for the exercises. The honorary degree of doctor of humanistic letters was awarded to Brig. Gen. W. Lee Hart, M. C., U. S. A., Ret., San Antonio, former medical director of the Eighth Service Command with headquarters in Dallas. The degree presented to the Army officer, who has been decorated by European and South American nations for research in tropical diseases, is the first honorary degree awarded by the college.

University of Texas Medical Branch Alumni Association members held a banquet in Galveston during the meeting of the State Medical Association in May, at which Drs. D. Bailey Calvin, B. I. Burns, George M. Decherd, and Donald Duncan, all members of the University staff, made brief talks. The creation of an alumni foundation was discussed and approved; reports on additional study of the project will be made at the 1947 meeting in Dallas. New officers have been announced by the secretary as follows: Dr. George M. Underwood, Dallas, president; Dr. Robert B. Homan, El Paso, president-elect; Dr. George V. Brindley, Temple, vice-president; and Miss Mildred N. Robertson, Galveston, secretary-treasurer.

A five hundred bed veterans hospital for Galveston, to be built and operated at government expense under the jurisdiction of the University of Texas Medical Branch, has been recommended by a government medical inspector, Chauncey D. Leake, Ph. D., vice-president and dean of the Medical Branch, has announced through the Galveston *News*. The hospital would include 250 beds for medicine and surgery and 250 for neuropsychiatry.

Dr. Felix L. Butte, clinical professor of orthopedic surgery at Southwestern Medical College, Dallas, addressed freshmen anatomy students at the University of Texas May 9, reports the Galveston *News*.

La Nacional Compania De Seguros Sobre La Vida, S. A., of Mexico City, has made a grant to the University of Texas Medical Branch to establish the Mexican Medical Fellowship in General Surgery. Dr. de Hoyos, Mexico City, has been appointed fellow for one year. The fellowship was established to increase medical coöperation between Mexico and the United States.

Morris Pollard, Ph. D., has been appointed assistant professor of preventive medicine at the University and director of the Virus Laboratory, following his discharge from the Army. He has recently been in charge of the Virus Laboratory of the Eighth Service Command at San Antonio.

Chauncey D. Leake, Ph. D., vice-president and dean of the University of Texas Medical Branch, was in Hawaii during May as the first postwar graduate medical lecturer for the Hawaii Territorial Medical Association. He gave a series of lectures on pharmacology and chemotherapy at Honolulu for the Association, spoke at the annual meeting of the Association, and offered special lectures before several county medical societies.

Smith, Kline, and French, Philadelphia, have granted $5,000 to the University of Texas Medical Branch for studies in hypertension under the direction of Dr. Eric Ogden, professor of physiology.

J. P. Roerig and Company, Chicago, have given $5,000 to the University for cytological studies conducted by C. M. Pomerat, Ph. D., professor of anatomy and director of the Tissue Culture Laboratory.

Two physicians from Syria are taking special postgraduate work at the University of Texas Medical Branch through the coöperation of the State

Department and the U. S. Public Health Service. Dr. Fayek Nahass is studying neuropsychiatry under the direction of Dr. Jack Ewalt, and Dr. Nukhtar Wasfi is studying radiology under Dr. Martin Schneider.

PERSONALS

Dr. Andrew J. Gray, Comanche physician for the past forty-six years, was honored at Tulane University in May when he attended commencement exercises as a member of the graduating class of fifty years ago, reports the Comanche *Chief*. Six members of the 1896 medical class were present to receive new "diplomas" and participate in special exercises and entertainments in their honor.

Dr. Everett C. Fox, president of Dallas County Medical Society, was named chairman of the professional division of the American Legion Endowment Fund drive launched in Dallas County in May to secure funds for an Americanism program, states the Dallas *Times-Herald*. The drive was in line with a statewide proclamation by Governor Coke Stevenson following designation of May 18 as "I Am an American Day" by President Harry Truman.

Drs. W. L. Crosthwait, Wesley W. Klatt, and *Neill O. Simpson*, Waco, spent a week of intensive study at Rochester, Minn., in May, according to the Waco *Tribune-Herald*. Dr. Klatt's work was in pathology, while Drs. Crosthwait and Simpson studied general and thoracic surgery.

Dr. L. Barnes, former Hubbard mayor, has announced his retirement from practice after fifty-five years because of a heart ailment, according to the Hubbard *News*.

Dr. James H. Black, Dallas, is a member of the board of trustees of the American Allergy Fund, national nonprofit society "dedicated to the exclusive support of study and research in allergy and the education of physicians and the public in this field," which was organized May 13, informs *The Journal of the American Medical Association*.

Dr. I. P. Sessions, for over thirty years health officer for Rockdale, has offered his resignation because of ill health, according to the Rockdale *Reporter*.

Dr. Clarence I. Shult and *Dr. J. H. Wooten, Jr.*, Columbus, have opened the Columbus Hospital and Clinic, states the El Campo *News*.

Dr. Austin M. Long, Valley Mills, has opened a clinic and laboratory, according to the Valley Mills *Tribune*. *Dr. T. A. Koerner*, at present in the Army and formerly of Coryell City, will be associated with Dr. Long upon his discharge in the fall.

SOCIETY NEWS

Bell County Society

April 3, 1946

(Reported by O. B. Gober, Secretary)

Acute Perforation of Peptic Ulcer—Terrell Speed, Temple.
Is the Ordinary Nonpigmented Mole as Innocent as We Think It Is?—Charles Phillips, Temple.

Bell County Medical Society met April 3 at the Kyle Hotel in Temple with twenty-four members and eleven guests present, to hear the above scientific program.

A resolution concerning the death of Dr. O. F. Gober, Temple, was read by John R. Winston.

E. D. McKay, H. B. Macey, Bert DeBord, S. W. Bohmfalk, and J. R. Burnett, were unanimously accepted for membership upon application.

Dallas County Society

May 2, 1946

Dallas County Medical Society on May 2 presented E. H. Cary, president of Southwestern Medical Foundation, in a public report on his recent appearance before the Senate committee conducting hearings on the Wagner-Murray-Dingell bills. Dr. Cary was called to make a statement and submit to cross-examination by the Senate Committee on Education and Labor because of his office as chairman of the National Physician's Committee.

Ellis County Society

May 5, 1946

Ellis County Medical Society and the Waxahachie Doctors' Club met in Waxahachie May 15, at which time the two organizations jointly adopted resolutions to submit to the city council. The resolutions pointed out that many common contagious diseases are transmitted by flies, especially in the presence of open toilets, and called for the city immediately to make available and mandatory sewage and water facilities for every house within the city limits.

Fayette-Colorado Counties Society

April 31, 1946

Fayette-Colorado Counties Medical Society was organized in Columbus on April 31 with a membership from Fayette County Medical Society and Colorado County Medical Society, which relinquished their charters in favor of the new society. Leo Peters, Schulenburg, was elected president; Frank Guenther, LaGrange, vice-president; C. I. Shult, Columbus, secretary-treasurer; and J. H. Wooten, Jr., Columbus, delegate.

The new society will meet the fourth Tuesday of each month, alternately at Columbus and LaGrange. Plans are to serve dinner each month.

F. J. L. Blasingame, Wharton, Councilor of the Eighth District, was present to assist in organizing the society.

Drs. Shult and Wooten conducted a tour of the Columbus hospital and supper was served by the hospital staff prior to the meeting.

Jefferson County Society

May 13, 1946

(Reported by L. R. Byrd, Jr., Secretary)

Anal Fissures and Anal Ulcers (motion picture)—Carl G. Giesecke, San Antonio.
Spinal Anesthesia—Lamar Bevil, Beaumont.

Jefferson County Medical Society met at St. Mary's Hospital, Port Arthur on May 13, with President George Sladczyk, Port Arthur, presiding.

The program as listed above was presented by W. P. Killingsworth, Port Arthur, chairman of the program committee. T. A. Fears, E. H. Lindsey, and T. M. Tyndall, all of Beaumont, and Dr. Sladczyk, discussed the presentation of Dr. Giesecke. J. Y. Harper and E. G. Ward, Port Arthur, and Drs. Fears and Tyndall discussed Dr. Bevil's paper.

The Secretary reported that the opinion of the society's attorney was that unpaid assessments were not covered in the by-laws concerning nonpayment of dues as of April 1 of a society year, and upon motion of L. C. Heare, Port Arthur, seconded by T. B. Matlock, Port Arthur, the matter was dropped.

Dr. Heare and L. C. Powell, Beaumont, reported on the annual session of the State Medical Association, just held in Galveston. A. R. Autrey, Port Arthur, moved that the society pay the expenses of Drs. Heare and Powell for the trip. The motion, seconded by J. W. Long, Port Arthur, carried.

Irma M. McFadden, speaking for the Quota Club of Port Arthur, offered the services of that organization in connection with a venereal disease education program which the medical society had under consideration. Dr. Fears, reporting for the Venereal Disease Committee, stated that the State Health Department and the U. S. Public Health Service had offered literature and other nonfinancial support toward the venereal disease education campaign in Jefferson County but would be unable to contribute financially.

Dr. Fears, for the Public Relations Committee, reported asking the State Medical Association for material to publish concerning the Wagner-Murray-Dingell bill. He urged full support of each physician in combating the bill.

Drs. Sladczyk, Heare, Killingsworth, and C. M. White, Beaumont, discussed the coming election of three representatives to the State Legislature from the Jefferson County area. President Sladczyk expected to appoint a committee to collect funds from society members for use in supporting candidates acceptable to the society.

Dr. White presented a resolution concerning the death of Dr. Talbot A. Tumbleson, Beaumont, which was adopted.

Paul N. Fortney and John M. White, Jr., were elected to membership upon application.

Karnes-Wilson Counties Society

May 21, 1946

Karnes-Wilson County Medical Society met May 21 at the home of J. W. Oxford in Floresville. After a fried chicken dinner the meeting was presided over by H. J. Bonnstetter, Kenedy, in the absence of President S. E. Shannon. Five members and three visitors were present.

W. A. King, former health officer of San Antonio, spoke on the poliomyelitis situation in the Karnes-Wilson region of the state, and other physicians discussed the subject generally.

Lubbock-Crosby Counties Society

May 7, 1946

(Reported by M. H. Benson, Secretary)

Medical Legislation—Mr. Syrian Marbut, Lubbock.

Lubbock-Crosby Counties Medical Society met May 7 at the Chatman Hospital, Lubbock, for dinner furnished by Dr. Chatman and a meeting. In addition to almost the entire membership, eight guests were present.

Pauline Miller, vice-president, presided over the business session in which it was decided a clinical-pathological laboratory, as proposed for Lubbock by W. O. Brown in a communication to the society, is not needed at present. Clarence Mast was elected to membership upon application.

Mr. Syrian Marbut discussed medical legislation as it affects medical practitioners from the time of their graduation from medical school to establishment of practice in a given locality.

A general discussion of chiropractors was entered into. Dr. Chatman mentioned a Negro doctor in Lubbock who makes false statements regarding cures. No solution was reached as to a method of redress.

McLennan County Society

May 14, 1946

Thrombophlebitis—Horace Trippet.
Knee Injuries—Howard Dudgeon, Jr.

McLennan County Medical Society and the Hillcrest Hospital medical staff held a joint meeting at the hospital May 14 to hear the scientific program listed above and a report of the recent State Medical Association meeting by H. R. Dudgeon, Sr.

Dr. Dudgeon, Jr., described the treatment of knee injury cases, excepting gunshot wounds, which he handled during his service with the army medical corps overseas. Dr. Trippet based his paper on prevention and treatment of preoperative and postoperative venous clotting in the legs on both army and civilian cases.

Tarrant County Society

June 4, 1946

(Reported by W. P. Higgins, Jr., Secretary)

The Treatment of Varicose Veins—Harold J. Shelley.

Tarrant County Medical Society met June 4 in the Medical Arts Auditorium, Fort Worth, with sixty-six members and two visitors present.

The paper named above was presented by Harold J. Shelley and was discussed by W. M. Crawford, T. H. Thomason, and Ted Lace.

A number of changes in the by-laws of the society were considered and eight such changes were adopted. Among the changes were provision for intern membership of medical school graduates licensed to practice and serving as interns or house physicians in Tarrant County hospitals, regular meetings on the first and third Tuesdays each month, a three-member Committee on Medical Economics to provide papers for reading at various meetings during the year, setting of dues for the various types of membership, making assessments payable within thirty days with members failing to make such payments liable for suspension, and limiting signs at residences or offices of physicians to customary usage including lettering not to exceed 3 inches in height.

A resolution from the Tarrant County Society of Medical Technologists was read by the Secretary and accepted and filed upon motion by W. S. Barcus.

Application for membership by Fred B. Aurin, Oscar W. Haffke, and Henry Stanford was approved.

Tom Green Eight County Society

April 1, 1946

(Reported by R. M. Finks, Secretary)

War Wounds of the Liver—Gordon F. Madding.

Tom Green Eight County Medical Society met in the Indian Room of the Cactus Hotel, San Angelo, April 1, with President W. Grady Mitchell presiding. Twenty-two members and guests were present.

The scientific program given above was carried out.

A report from the committee on hospital and medical service was made by R. L. Powers, chairman.

Upon motion of F. T. McIntire, seconded by W. J. Swann, the society went on record favoring renomination of R. E.Windham as Councilor of the Fourth District.

The resignation of J. Frank Jones was read. K. B. Round moved, seconded by Dr. Powers, that Dr. Jones be offered honorary membership, but Dr. Jones declined.

W. D. Anderson moved, seconded by Perry J. C. Byars, that the society meeting of May 6 be postponed because of the conflict with the State Medical Association meeting. It was agreed that the next meeting would be held in June.

Wharton-Jackson-Matagorda-Fort Bend Counties Society

May 14, 1946

(Reported by J. M. Bauknight, Secretary)

Surgery in Hydronephrosis—Tom Guthrie, Houston.

Wharton-Jackson-Matagorda-Fort Bend Counties Medical Society met at Wharton on May 14 with a good attendance. Tom Guthrie, guest speaker from Houston, spoke on "Surgery in Hydronephrosis."

President W. S. Thiltgen appointed the following legislative committee: Charles A. Shoultz, Bay City; R. G. Johnson, New Gulf; Borden McGee, Rosenberg; and J. M. Bauknight, Ganado.

Wichita County Society

Wichita County Medical Society has pledged coöperation with the Veterans Administration in securing a full-time physician for the Veterans Administration contact office in Wichita Falls for treatment of men entitled to medical attention. Tom R. Rayburn, manager of the Dallas Regional Office of the Veterans Administration, and J. Forsythe Rowe, chief medical officer of the office, conferred with the medical society. Dr. Rowe said a part-time physician might also be placed on duty in Wichita Falls.

Fourteenth District Society

June 11, 1946

(Reported by V. L. Tuck, Secretary)

Fourteenth District (North Texas) Medical Society held an all day meeting June 11 in Gainesville under the direction of C. B. Thayer, Gainesville, president; V. L. Tuck, Sherman, secretary-treasurer; and C. C. Nash, Dallas, Councilor.

The following program was given:

MORNING—MEDICAL SECTION

C. D. Strother, Sherman, chairman, and Doak Blassingame, Denison, secretary, presiding.

Injuries of the Carpal Bones and Their Treatment—Harry Farber.
Discussion—Felix Butte, Dallas.

Rheumatic Fever from the Standpoint of the General Practitioner—Taylor Pickett, Dallas.
Discussion—Don Freeman, Denison.

The Rh Antigens—Harrer F. Marsh, Oklahoma City, Okla.
Discussion—Joe Ackert, Denison.

Thrombophlebitis and Phlebothrombosis—Raymond Patzer, Oklahoma City, Okla.
Discussion—Frank Sporer, Van Alstyne.

AFTERNOON—SURGICAL SECTION

Scott Wysong, McKinney, chairman, and Scott Hammond, Paris, secretary, presiding.

The Extruded Intravertebral Disk—Casey Patterson, Dallas.
Discussion—C. C. Nash, Dallas.

Urethral Section—John M. Pace, Dallas.
Discussion—Henry W. Maier, Greenville.

Chronic Stenosing Regional Enteritis and Enterocolitis—R. L. Lewis, Jr., Paris.
Discussion—V. L. Tuck, Sherman.

Early Ambulation in Surgery—Robert Sparkman, Dallas.
Discussion—Scott Wysong, McKinney.

BOOK NOTES

[1]**Hospital Care of the Surgical Patient.** A Surgeon's Handbook with an Appendix on the Treatment of Wounds. By George Crile, Jr., M. D., Surgeon, Cleveland Clinic, and Franklin L. Shivly, Jr., M. D., Assistant Surgeon, Cleveland Clinic. Foreword by Evarts A. Graham, M. D., Bixby Professor of Surgery, Washington University School of Medicine, St. Louis. Second edition. Cloth, 288 pages. Price $3.50. Charles C. Thomas, Publisher, 1946.

This little book was originally written for the information of the surgical residents at the Crile Clinic. It certainly should be in the hands of every intern and resident on the surgical services of every hospital. In spite of the fact that it is written simply, and covers largely basic principles, it has a great deal of valuable information for the general practitioner and full-time surgeon. The book is divided into several sections, the first of which is a rather extensive discussion of the physiological principles related to the care of the surgical patient. Such matters as water balance, chloride balance, and serum protein levels are taken up. Also, in this section is a fine discussion of the physiology and pathology of wound healing and factors which may adversely affect it.

The second section, I believe, is the most interesting and important of the book. It concerns the management of surgical complications. There are a great many ordinary, simple things which are necessary in the care of the surgical patient which are discussed in this section but which are seldom found in the average surgical textbook. Among such things are the management of fecal impactions, urinary tract infections, overdistention of the bladder, cardiac complications, and intestinal fistulas. A good discussion of the modern concept of the treatment of shock and burns is also found here. Thrombophlebitis, phlebothrombosis, and pulmonary embolism are briefly discussed and the currently accepted treatment is outlined.

Section three is on the preparation of the patient for operation, with such routine matters outlined as physical examination, the usual routine laboratory studies, preparation of the operative field, caring for the bowels and urinary tract, and sedation. There is a brief section on the choice of anesthesia. The last half of section three is occupied with the preoperative care for special major procedures such as gastric surgery, colon surgery, rectal surgery, and operations in the presence of jaundice.

Section four is a concise outline of the postoperative care of the surgical patient, taking up first the various complications such as gas pains, vomiting and constipation, and then the special care following the different types of major surgery.

Section five is an outline of the major hospital procedures which the average intern, resident, or general practitioner may be called upon to do, as, for example, lumbar puncture, catheterization, venous puncture and tracheotomy.

Section six, on the relation of the house officer, should be most valuable to the newly graduated medical student who is just beginning his internship. It gives a great deal of good advice to those who are not acquainted with the usual hospital routine and relationships of the house doctor to the patients, nurses, and attending staff members.

The book is concluded with an appendix on the treatment of wounds which should be helpful to anyone who is required to do emergency surgery, and especially to those who care for the emergency room in the hospital.

[1]Reviewed by Henry Stanford, M. D., Fort Worth, Texas.

DEATHS*

Dr. Charles Martin Hoch, of Smithville, Texas, died April 19, 1946, of coronary disease.

The son of August and Caroline Hoch, Dr. Hoch was born October 28, 1884, at Hochheim, Texas. He attended Coronal Institute at San Marcos and the University of Texas at Austin before receiving his medical education at the University of Texas Medical Branch in Galveston, from which he was graduated in 1910. After serving an internship at St. Mary's Infirmary at Galveston, Dr. Hoch practiced for two years at Pearsall and worked with Rockefeller Foundation one year before locating at La Grange, where he practiced for twenty-five years. Ill health caused his removal to northwest Texas, where he practiced for four years at Bryson, in Jack County. In April, 1942, Dr. Hoch suffered a coronary

DR. CHARLES M. HOCH

*An obituary ordinarily will not be published more than four months after date of death. Coöperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

occlusion, which forced him to remain inactive for about a year. He then became associated with his son, Dr. Martin Hoch, and the Hoch and Hoch Clinic was established at Smithville. As health permitted, Dr. Hoch continued to serve at the Clinic until his death.

Continuously from 1913 throughout his professional career, Dr. Hoch was a member of the State Medical Association and American Medical Association, successively through Fayette County Medical Society, Young-Jack-Archer Counties Medical Society, Baylor-Knox-Haskell Counties Medical Society, and Bastrop County Medical Society. He was secretary of the Fayette County Medical Society in 1933, and president of the same society in 1935. Following his rejection when he attempted to enter the medical corps of the Army during World War I, Dr. Hoch served the local Selective Service board, receiving a citation from President Woodrow Wilson for his work. Dr. Hoch was a member of the Methodist Church and was active in civic organizations until his health interfered.

In 1911 Dr. Hoch was married to Miss Sadie L. Martin, of Graham, who survives. Two of their children, Dr. Martin Hoch and Mrs. Caroline Hoch Kuon, both of Smithville, also survive. A son, Phlete A. Hoch, was killed in combat in the Pacific during World War II as a pharmacist, second class, in the Navy. One brother, John Hoch, and four sisters, Mrs. Otelia Steen, Mrs. Mattie Littlefield, Mrs. Lizzie Jacobs, and Mrs. Emma Boothe, all of Yoakum, survive.

Dr. G. A. L. Kusch, of Gay Hill, died of a stroke May 21, 1946, in a Brenham Hospital.

Dr. Kusch was born January 17, 1876, at Bay City, Mich., the son of K. G. A. and Elizabeth (Ladrick) Kusch. He came with his parents to Grayson County, Texas, in 1884. He attended school at Enterprise, Grayson County, and was graduated with honors from the University of Texas Medical Department in 1898. He began practice in Pottsboro, Grayson County, but in 1909 moved to Gay Hill, where he practiced continuously until his death.

DR. G. A. L. KUSCH

Throughout his professional career Dr. Kusch was a member of the State Medical Association and the American Medical Assotion, first through Grayson County Medical Society and then through Washington County Medical Society. He was president of the Washington County Society in 1933, 1936, and at the time of his death, 1946. He had served in the House of Delegates of the State Medical Association many years. Members of the House of Delegates particularly will remember his many years of service as a member of the Credentials Committee. He was also a member of the Eighth, Ninth, and Tenth Districts Medical Society. For a number of years Dr. Kusch was a member of the Texas Pharmaceutical Association. He was a member and for a number of years financial secretary of Woodmen of the World, an honorary member of Odd Fellows, and a member of Sons of Hermann. He belonged to the Christian Church. Dr. Kusch was a former president of the Citizens State Bank of Somerville, and at the time of his death was vice-president. He was a director of the Somerville Bank, the Farmers National Bank, Brenham, and the Sarah B. Milroy Memorial Hospital, Brenham.

On February 10, 1909, in Galveston, Dr. Kusch married Miss Carrie Werner, who died January 25, 1914. Surviving is the former Mrs. Emma Luedemann, whom Dr. Kusch married July 1, 1925. Two daughters of the first marriage, Mrs. Arnold H. Gohlke, Denison, and Mrs. Ferriss E. South, Fort Worth, survive. A son, Adolph Ray Kusch, died in infancy. Other survivors include two sisters, Mrs. R. G. Kegley and Mrs. Roy Garrison, both of Henrietta, and two brothers, O. F. Kusch, Sherman, and A. W. Kusch, Denison.

Dr. Edgar Poe Shelton, of Dripping Springs, Texas, died of cerebral hemorrhage May 30, 1946.

The son of Dr. James K. Polk and Cornelia (Ellison) Shelton, Dr. Shelton was born June 1, 1867, in Smith County, but moved shortly to Bell County. He attended the schools of Bell County and high school in Austin, in 1891 going to Hospital College in Louisville, Ky. He was honor man in his freshman year, but interrupted his education to practice for several years in Dripping Springs before returning to secure his medical degree with second honors in 1897. He returned to Dripping Springs and served that community and the surrounding hill country until his death.

DR. EDGAR POE SHELTON

Dr. Shelton was a member at various times during his career of the State Medical Association and American Medical Association, the last year in 1944. He was a president of Hays County Medical Society and was the first president of Hays-Blanco Counties Medical Society upon its organization in 1934. A lifetime Democrat, Dr. Shelton boasted that he had not missed a State Democratic convention since he was 21 years of age. He represented Hays County for two terms in the House of Representatives, at which time he actively supported the causes of medicine and public health. He was the personal friend of every Texas governor from James Stephen Hogg to date. His father at the age of 17 had been a captain in the Confederate army, later serving as a colonel in Maximillian's army, and Dr. Shelton was a member of the committee which raised money to purchase the Confederate Reunion grounds at Driftwood, Camp

Ben McCullough, and served as chairman of the board of managers since establishment of the Camp. He was an active member of the Dripping Springs Masonic Lodge, which he served as master on several occasions.

Dr. Shelton is survived by his wife, the former Miss Lula Mae Spaw, whom he married December 6, 1892, twelve of his thirteen children, thirty-seven grandchildren, and eleven great grandchildren. Also surviving is a brother, Major Horace H. Shelton, Austin. The surviving children include seven sons, Elbert, Burnet; Robert, Nacogdoches; Ellison, Lolita; Roy, Daisetta; Ralph and Clarence, San Antonio; and Vaughn, Dripping Springs; and five daughters, Mrs. Neva Garner, Navasota; Mrs. Faye Cox, Beeville; Mrs. Ora Powell, San Antonio; Mrs. Lois Boone, Navasota; and Mrs. Willie Edna Wolf, Lampasas.

In 1941 an all-day celebration honoring Dr. Shelton upon fifty years of practice in Dripping Springs was held at Camp Ben McCullough with more than 1,000 relatives and friends in attendance. Many of the celebrants had been brought into the world by Dr. Shelton, and it was reported that his records showed that he had delivered 3,998 babies during his professional career.

AUXILIARY NOTES

Officers of the Woman's Auxiliary to the State Medical Association of Texas: President, Mrs. George Turner, El Paso; President-Elect, Mrs. C. F. Ferguson, Beaumont; First Vice-President, Mrs. L. B. Windham, Tyler; Second Vice-President, Mrs. V. M. Longmire, Temple; Third Vice-President, Mrs. R. E. Clark, Memphis; Fourth Vice-President, Mrs. J. E. Hogan, Big Spring; Corresponding Secretary, Mrs. Robert F. Thompson, El Paso; Recording Secretary, Mrs. M. A. Ramsdell, San Antonio; Publicity Secretary, Mrs. J. F. Campbell, Fort Worth; Treasurer, Mrs. Guy Jones, Dallas; Parliamentarian, Mrs. Joe Nichols, Atlanta.

Mrs. George Turner, twenty-ninth President of the Woman's Auxiliary to the State Medical Association of Texas, was born in Iredell, Bosque County, Texas, the daughter of Mr. and Mrs. T. A. Johnson. When she was 10, the family moved to Walnut Springs, where she remained until her graduation from high school. She was later graduated from the Southwest Texas Normal School at San Marcos, with home economics as her major. She holds a permanent teacher's certificate from this institution. In further preparation for her work as a teacher, she did special work in home economics and teaching methods at the George Peabody College for Teachers in Nashville, Tenn.

MRS. GEORGE TURNER

Following these years of preparation she taught one year in a county school at Clifton, two years in the home economics department of the high school at Carrizo Springs, and two years in the home economics department of the Southwest Texas Normal School at San Marcos, her alma mater.

She was married in Austin, in 1918, to Dr. George Turner, of Iredell, who was then serving in World War I. At the close of the war the couple located in El Paso, where Dr. Turner established a practice in radiology and clinical pathology. They have lived in El Paso for twenty-seven years..

They have two daughters: Jeanne, who will receive her master of music degree from Southern Methodist University this spring, and Ann, a sophomore student in the same school, majoring in home economics and dietetics.

Mrs. Turner's chief interests are her home, her husband, and her daughters, whose accomplishments and interests she shares. While they are her first consideration, she finds time to contribute to many religious, social, civic, and philanthropic organizations and enterprises.

She is a member of Trinity Methodist Church of El Paso, where she has taught a class in Sunday school for twenty years, being active also in the Woman's Society of Christian Service.

She is a charter member of the Woman's Auxiliary to the El Paso County Medical Society, which she has served as president and in various other capacities. She served as Corresponding Secretary to the State Auxiliary during 1936-1937 and as State Historian 1943-1944. She has also served as Council Woman for the First District.

Mrs. Turner was president of Crockett School P. T. A. for two years and served in various capacities in the Austin High School P. T. A. during the years that her daughters were students there.

She is a member of Chapter N, Texas, P. E. O. Sisterhood, which organization she has served as corresponding and recording secretaries, chaplain, guard, vice-president, and president, in addition to serving on many important committees.

She is a member of the Woman's Division of the El Paso Chamber of Commerce, the Woman's Club of El Paso, the Woman's Auxiliary to the College of Mines, the American Red Cross, the Mothers' Health Center, and the El Paso Garden Club.

With all of her accomplishments and honors, Mrs. Turner is modest and unassuming, sympathetic and understanding in all her relationships. With a friendly and gracious personality, linked with an enduring sense of humor, she is at home with every one, whether it be in her hospitable home or as leader or follower in her various activities. While she possesses the qualities of successful leadership, she is coöperative and useful wherever and whenever opportunity occurs for service to her family, her community, and her country.

She will lend to her administration as President of the Woman's Auxiliary to the State Medical Association the untiring and enthusiastic effort for which her natural endowments and her training have fitted her.

She has announced as the slogan for her administration: "OLD PROJECTS—NEW VIGOR."

Past President's Dinner.—The annual dinner of Past Presidents of the Woman's Auxiliary to the State Medical Association, was held at the Buccaneer Hotel, Galveston, on the evening of May 6, 1946, with Mesdames R. B. Homan, El Paso; John T. Moore, Houston; H. C. Haden, Houston; and M. L. Graves, Houston, as hostesses. The table was beautifully decorated with pink rose buds and colonial figurines. Places were laid for twenty, which was a record attendance. At each plate was a lovely present, the handiwork of Mrs. Graves.

Mrs. Homan asked Mrs. O. M. Marchman, Dallas, to act as secretary and Mrs. S. F. Harrington, Dallas, to call the roll. She also gave a genuine welcome to all and asked that each one respond to roll call by telling some humorous or interesting experience that

happened during her administration. Mrs. Haden gave a toast to all, both past and present, and greetings were read from the absent ones, Mrs. S. A. Collom, Texarkana; Mrs. Henry Trigg, Fort Worth; Mrs. Joe Gilbert, Austin, and Mrs. W. A. Wood, Waco.

After a song of "thank you" to Mrs. Graves and a vote of thanks to all four hostesses the dinner was concluded.—Mrs. O. M. Marchman, Dallas, Acting Secretary.

AUXILIARY NEWS

Bowie-Miller Counties Auxiliary met May 24 at the home of Mrs. William Hibbitts, Texarkana, with Mesdames S. A. Collom, Sr., P. H. Phillips of Ashdown, Ark., and Brooks Tate as cohostesses.

The president, Mrs. Hibbitts, presided while committee reports were read. An account was given of the state meeting in Galveston, at which Bowie-Miller Auxiliary was awarded blue ribbons for Hygeia and public relations work.

Several members had had perfect attendance records during the year, but Mrs. Ralph Cross won the prize in a drawing for first place.

Mrs. Hibbitts introduced the new president, Mrs. N. B. Daniels, and other new officers. Mrs. Daniels spoke briefly and announced the committees for the year.

Fayette-Colorado Counties Auxiliary was organized April 31 in Columbus when a medical society covering the two counties was organized. Mrs. J. H. Wooten, Jr., Columbus, was elected president; Mrs. Thomas Youens, Weimar, vice-president; and Mrs. C. I. Shult, Columbus, secretary-treasurer.

Hunt-Rockwall-Rains Counties Auxiliary met May 14 at the home of Mrs. S. D. Whitten, Greenville. Mesdames Leslie Bush, Ann Becton Boykin, Truett Crim, Frank Parker, Benton Clark, W. B. Reeves, and H. W. Bradford were cohostesses.

Members answered roll call with the names of doctors who have contributed to fine arts. Mrs. M. L. Wilbanks gave a devotional, and Mrs. E. T. Crim reported that at the state meeting in Galveston Hunt-Rockwall-Rains Auxiliary had won three blue ribbons for excellence in health talks, publicity reports, and philanthropies.

Mrs. J. W. Ward introduced Mrs. H. O. Norwood, who reviewed "The Gauntlet" by James Street. As the author received his inspiration for the book from Lowell's "The Vision of Sir Launfel," Mrs. Norwood introduced her talk by a brief review of the poem.

Following the program members and guests were invited to the dining room, where Mrs. W. P. Philips presided at a punch bowl set on a lace covered table centered with a crystal bowl of pink hydrangeas and roses on a mirror plaque. The buffet was decorated with pink hydrangeas and green tapers.—Mrs. B. F. Arnold, president.

Kerr-Kendall-Gillespie-Bandera Counties Auxiliary held its final meeting of the year June 7 at the home of Mrs. Sam Thompson, Kerrville. Twelve members and several guests attended. The new officers were installed, and Mrs. Lester Keyser, Fredericksburg, presided.

Projects of the auxiliary in the past were discussed. It was agreed to continue sponsorship of tuberculosis seal sales, patch tests for school children, and efforts to secure a health nurse for the public schools.

After a brief report by Mrs. Thompson of the state convention in Galveston, the meeting was adjourned until fall.

Refreshments were served with Mesdames McWilliams and Jones, house guests of Mrs. Thompson, presiding at the tea table.—Mrs. David McCullough, secretary.

Tom Green Eight County Auxiliary met May 20 at the home of Mrs. R. M. Finks, San Angelo. Mrs. Finks conducted a business session at which committee reports were made and a report on the state convention in Galveston was given by Mesdames Victor Schulze and J. C. Byars.

It was voted to assist the local Catholic women's organization in collecting food for Europe and to continue efforts to secure for San Angelo sponsorship of a cancer control and research unit.

New officers were installed as follows: Mesdames R. M. Arledge, president; A. L. Lewis, first vice-president; Leon Hutchins, second vice-president; W. Grady Mitchell, secretary; R. M. Finks, treasurer; Jerome Smith, parliamentarian; and Victor Schulze, publicity secretary.

Mrs. H. Kermit Brask was introduced as a new member.

Refreshments were served to thirteen.

TRANSACTIONS
OF THE
TWENTY-EIGHTH ANNUAL SESSION
OF THE
EXECUTIVE BOARD AND DELEGATES
WOMAN'S AUXILIARY
TO THE
STATE MEDICAL ASSOCIATION
OF TEXAS

GALVESTON, MAY 6-9, 1946

PRE-CONVENTION EXECUTIVE BOARD MEETING

The Executive Board of the Woman's Auxiliary to the State Medical Association of Texas met in a luncheon and business session at 1:00 p. m., Monday, May 6, 1946, at the Buccaneer Hotel, Galveston, Texas, with the President, Mrs. Charles B. Alexander, San Antonio, presiding.

The invocation was given by Mrs. E. H. Marek, Yoakum.

Mrs. Paul Brindley, Galveston, gave the address of welcome from the Galveston County Auxiliary to the Executive Board of the State Auxiliary as follows:

ADDRESS OF WELCOME

Emerson said in his *Journal* that "Hospitality consists of a little fire, a little food and a great quiet." The first nature has provided for you; the second we have tried to arrange; but the powers that be have defeated us in the last.

Galveston feels as though she were welcoming you home. Many of your husbands, and some of your sons, finished school here. Some of you were Galveston girls. Others of you taught school, worked, married, and lived here. We hope you have the warm spot in your hearts for us that we have for you. If any of you is here for the first time, we greet you warmly and trust that when you return, you, too, will be an old friend.

In welcoming the Executive Board of the State Auxiliary, I bear in mind your importance. It is you who realize that a physician's wife is a leader in her community whether or not she wants that position or is equipped to fill it. If she is well informed, has the good of the people of her community at heart, does her share of civic and welfare work,

then her associates will do likewise; and fortunate indeed is her husband and her city. And vice versa.

Today when no woman has time for unessentials, it is your wisdom, your courage and foresight which will streamline auxiliary activities and air condition auxiliary thinking so that every doctor's wife not only will want to be a member but will want a part in the work which makes the organization a dynamic force for good in each locality in the state.

A response was given by Mrs. M. L. Graves, Houston, as follows:

Response to Address of Welcome

After having the inspiring address of Mrs. Paul Brindley, who received part of her education in Bell County, I am proud to say that was my home too. However, many of the happiest days of my life were spent upon this dearly beloved island. One has to live here to know just how fine its people are and I invite myself back often. But today I wish to pay special homage, not only to our women, the wives of physicians, but especially to our sweethearts and husbands, and so I read you a little poem written years ago by a lovely young woman, a patient here in John Sealy Hospital.

Wishin'

"I've been lying here awishin' cause I'm idle for a spell
That I had a big gold mine or something I could sell;
Then I'd buy a splendid present, something beautiful and grand
So I could come right straight to you and put it in your hand.
For kindnesses you've shown me my gratitude runs deep;
It makes a glad spot in my heart, a memory that I'll keep.
But I haven't any gold mine or little I could sell
And it seems such a small thing just to say I wish you well,
And yet I say it every day and add a prayer or two:
I pray that all the good in life will always come to you,
For if there is a soul on earth I think God is closest to
Its one great kindly man I know and that same man is YOU."

Mrs. S. F. Harrington, Dallas, presented the past presidents by "giving their hobbies."

Mrs. George Turner, El Paso, President-Elect, was introduced, and her message follows:

Address of President-Elect

"Time flies and draws us with it. The moment in which I am speaking is already far from me" (Boileau), and so it seems only a moment ago that we were in San Antonio and I had been asked to be your President-Elect. It is a pleasure to be here today; especially, since we know that world conditions have changed to the extent that we are permitted to return to the procedure of our regular state convention.

It was with a great deal of interest that I read the account of each of our past twenty-eight years as an Auxiliary and I must take this opportunity to express appreciation to those who have builded so solidly—each President and her official family adding to the structure until in no state is there a medical auxiliary of such unexcelled achievements. This edifice is a challenge to us, as we come up to take our turn as the builder. Especially must I pay tribute to and thank Mrs. Alexander for her personal help, her unfailing cheerfulness, her ability to meet situations and discharge them quickly, capably, and tactfully. This last addition, the twenty-eighth room, to our already beautiful medical auxiliary mansion (for any house with twenty-eight rooms is surely a mansion) is most beautiful, useful, and inspiring. All in all, our work has been in master builders' hands and so it is with courage inspired by them that we look into the preparation for a new year's work—1946-1947.

You have heard it declared that there is nothing new under the sun but that is not true in our sense of the word—what could be newer than our next year's work? It is an old custom to begin any new undertaking with resolutions as to how it shall be accomplished. Resolutions are directly related to ideals and ambitions, both of which are steps toward setting and reaching aims. With this idea in mind, Mrs. Alexander has asked me to announce a school of instruction for new officers, council women, and committee chairmen and committee members. Every retiring state officer and chairman will hold a class of instruction for the incoming state and county officers and chairmen on Wednesday, May 8, from 3:00 to 4:00 p. m. in the hotel suite of the retiring state officer or state chairman. There are two exceptions: namely, (1) the class for county presidents and county program chairmen will be held in the Buccaneer Hotel Solarium and will be taught by Mrs. Frank Haggard, San Antonio, past Bexar County president, past state president, past national president, and past president of Southern Medical Association Auxiliary, and (2) the school of instruction for incoming and outgoing council women will be held at a no host luncheon on May 7, at 12:30 p. m. in the Buccaneer Hotel Solarium, with Mrs. S. M. Hill, Dallas, first vice-president and chairman of organization, as the instructor. The object of this school is to acquaint officers and committee chairmen of their duties before they have to assume them. We think this is a decided step forward and we hope that its effect will be felt in next year's work by eliminating uncertainty and indecision which results from poorly defined aims and duties. And so it is with pride that I say to you, "There is something new under the Texas Auxiliary sun—our First Annual School of Instruction for State and County Officers and Committee Members."

The officers, war presidents, and Mrs. H. F. Connally, Waco, wife of the President of the State Medical Association, were introduced by the President.

Dr. Merton M. Minter, San Antonio, member of the Public Relations Committee, State Medical Association, gave a very helpful and inspiring address on "Public Relations," a summary of which follows:

Synopsis of Address of Dr. Merton M. Minter

There are two major problems facing the medical profession today. One is the problem of providing adequate medical care to all of the people at a price they can afford to pay. The second is the problem of keeping this program in the hands of the doctors who best understand the problem and its administration, rather than in the hands of the government where political interference would eventually and surely occur.

The American Medical Association and the county medical societies have within the past few months made great strides towards providing care for all of the people. These organizations have definitely endorsed the program of prepayment medical and surgical, and hospitalization contracts. An organization has been set up within the A. M. A. to study proposed plans, to coördinate all of the plans, and to give its stamp of approval to those which offer the best protection at the most reasonable cost. It is hoped that state societies will push these plans to the utmost and it is hoped that profit and nonprofit organizations will sell these contracts to as many people as possible so that the best possible coverage and the greatest possible benefits to the policy holders will reach down to the people who need it

the most and are the least able to afford medical care. The Executive Council of the State Medical Association of Texas has definitely endorsed one such plan and I feel sure that it will continue to endorse others which meet its approval. Approval does not in any way depend upon those selling the policy but depends on the policy being such that it will give adequate protection at a low cost commensurate with sound business principles, and adequately financed. We physicians believe that this type of insurance for the people by their choice is much better than forced taxation in the hands of bureaus and centralized government. We believe that it is the best answer to socialized medicine and we believe that it is a far better solution of the problem of sound and adequate medical care for the public.

The second major problem facing the profession is the one of convincing the people and, indirectly or directly, the Congress, that a voluntary approach is better than a compulsory one. You and I know that this is true. We know that in every country where compulsory health insurance has been imposed the quality of medical care has deteriorated and that the expense has increased. We know that it has not reduced illness in the country. We know that the American system of medicine is the finest that has been developed. We also know that it is not perfect but we are striving for perfection. We feel that voluntary insurance is a step in that direction.

The National Physicians Committee, A. M. A., your own State Medical Association, and your Public Relations Committee have all done a great deal of work in trying to solve the problem of medical care. I wish to call your attention to the fact that we are not against any measure for the benefit of national health. We are all for such measures. We are for the Hill-Burton bill which would provide medical service in sparsely settled areas and in areas where there is not enough per capita wealth to support first class medical care. We are for the Magnuson bill which would provide funds for research. We are against the Wagner-Murray-Dingell bill because of its compulsory health features and because of its centralization in the hands of one man of tremendous sums of money to be spent presumably for the health of the nation. We are against the Pepper so-called maternal-child welfare bill because it gives care to people who are well able to pay for medical care and places doctors again under the direction of a federal bureau. We are for the provisions which would care for mothers and little children who are unable to provide care for themselves. We are for all bills which will advance the health of the nation and we are against bills which by every analysis would retard the health of the nation, enslave the doctors, and be a tremendous expense to the taxpayers.

I think it is well to point out that compulsory health insurance is neither compulsory, insurance, nor healthy. Nothing is compulsory except taxes and you cannot force anyone to obtain or give medical care. It is not insurance because it is not based on actuarial figures and no one knows what its cost will be. It is not healthy because in every country in which it has been tried the health of the nation has not improved.

The President announced that the reading of the minutes of the last Board meeting would be dispensed with inasmuch as they had been published in the JOURNAL.

Mrs. Wilber F. Robertson, San Antonio, was appointed recording secretary and Mrs. Frank Haggard, San Antonio, parliamentarian for the convention.

The following committees were appointed by Mrs. Alexander:

To approve minutes: Mrs. E. W. Coyle, San Antonio; Mrs. W. M. Hibbitts, Texarkana; and Mrs. L. B. Windham, Tyler.

Resolutions: Mrs. W. S. Red, Jr., Houston; Mrs. Scott Applewhite, San Antonio; Mrs. R. B. Homan, El Paso; Mrs. S. H. Watson, Waxahachie; and Mrs. Ramsay Moore, Dallas.

Mrs. S. M. Hill, Dallas, was asked by the President to read the report of this meeting to the General Assembly.

The President called for recommendations from the officers and chairmen of the standing committees.

Recommendations by Mrs. F. R. Rugeley, Wharton, treasurer, were referred to the Reference Committee.

Mrs. A. B. Pumphrey, Fort Worth, Legislative Committee, requested that the members coöperate when letters were sent to them.

The Student Loan Fund Committee was instructed to write a letter in regard to loans to first and second year medical students.

Mrs. R. B. Homan, El Paso, recommended a revision to the Constitution, Article 5. This recommendation was referred to the Reference Committee.

Mrs. H. R. Dudgeon, Waco, in the absence of Mrs. W. A. Wood, chairman of the Archives Committee, moved that the Archives Committee be empowered to reprint the historical chart as printed in 1941, bringing this chart up to date. The motion was seconded and carried.

Mrs. Alexander closed the meeting with the following remarks:

CLOSING REMARKS OF PRESIDENT

Another year has rolled by all too quickly and this is the last meeting of this Executive Board. No president could have had a more loyal and efficient Board and it has been a joy and a satisfaction to work with each of you. I wish to express to you past presidents my deep appreciation for your continued interest and valued counsel. To all of you officers and chairmen and council women and county presidents I wish to extend my sincere thanks. It is you who have carried on the work of this Auxiliary and it is through your efforts that much has been accomplished. It has been a pleasure and a privilege to work with each of you. I wish to thank our hostess president, Mrs. Paul Brindley, for the long hours and the tremendous amount of work expended upon this convention. I am most grateful to the committee who arranged for this lovely luncheon today: Mrs. A. N. Boyd, Mrs. Hughes Gilliam, and Mrs. P. R. Denman. I thank each of you who took part on this splendid program today. Let me thank all of you again and again for your labor, for your loyalty, and most of all for your love.

There being no further business the President declared the meeting adjourned, sine die.

MRS. WILBER F. ROBERTSON, San Antonio,
Recording Secretary.

OPENING MEETING AND FIRST GENERAL ASSEMBLY

The twenty-eighth annual session of the Woman's Auxiliary to the State Medical Association of Texas convened at 11:00 a. m. in the Ballroom of the Buccaneer Hotel, Galveston, Texas, May 7, 1946, with Mrs. Charles B. Alexander, San Antonio, presiding.

The invocation was given by Mrs. H. R. Dudgeon, Waco.

The address of welcome was given by Mrs. John Otto, president-elect of the Galveston County Auxiliary, as follows:

Address of Welcome

I am delighted, on behalf of the Woman's Auxiliary to Galveston County Medical Society, to welcome you to our city. We have looked forward to this meeting with the sincere hope that you will enjoy and profit by your visit. This being the first meeting after the war we feel that everyone is enthusiastic and eager to get back into the spirit of the Auxiliary, therefore, making this one of the best years in our history. The island is here for your pleasure. Do with it as you may.

Mrs. J. H. McCracken, Jr., Dallas, gave the response to the address of welcome:

Response to Address of Welcome

It is indeed a pleasure to attend again a State Auxiliary meeting, after four years of war, when it was impossible for us to meet. I am sure I speak for all when I say we are delighted to have this meeting in this beautiful island city of Texas, which is one of its oldest and most interesting cities. Galveston received its name in honor of Conde de Galvez, Viceroy of Mexico and Governor of Louisiana and Texas, in the year 1782. From the days of Jean Lafitte to the present, Galveston has played an interesting part in the history of Texas. It is our largest coastal defense and has contributed greatly to the medical history of our state, through its State Medical School. Your welcome carries with it a genuine cordiality and in the name of the State Auxiliary, I accept your gracious hospitality.

The President announced that the reading of the minutes would be dispensed with inasmuch as they had been printed in the Journal.

The report from the Executive Board was given by Mrs. S. M. Hill, Dallas.

Mrs. Hill, first vice-president, took the chair while Mrs. Alexander, President, gave her report, which follows:

Report of President

I come before you today to express my appreciation for the privilege of being President, and to render an account to you of my activities for the past year. This has been a very happy, a very interesting, and a very busy year. I have traveled thousands of miles and written hundreds of letters in the interest of the Auxiliary. I have attended twenty auxiliary meetings, each one filled with cordiality, understanding, and coöperation. I shall treasure always your delightful friendships, your charming entertainments, and your hospitable homes. Please let me thank you again for inviting me to visit your auxiliaries, for receiving me so graciously, and for accepting my message from the State Auxiliary. Much to my regret I was unable to accept all invitations because of conflicting engagements and other duties.

In December I attended the National Conference of State Presidents and Presidents-Elect in Chicago where I gave a report from the Texas Auxiliary and served on the Resolutions Committee. It was this conference that inspired your President and President-Elect to have during this convention a school of instruction for all new state and county officers and chairmen. It is our earnest desire that each of you attend the Wednesday afternoon conference in which you as an Auxiliary worker are most interested. Each state chairman at the time of her report this morning will announce the meeting place of the conference which she will lead.

As State President it has been my privilege to conduct three meetings of the State Executive Board. It was my pleasure to have forty-three members of the Executive Board as my guests for breakfast at the Post Executive Board meeting in San Antonio last May. A form letter was sent in July outlining the program adopted at the May meeting and announcing the next Executive Board meeting in San Antonio in September. The importance of an informed membership was stressed at the September meeting. In keeping with this theme Dr. John H. Burleson, San Antonio, chairman of the Legislative Committee, and Dr. R. A. Miller, San Antonio, member of the Public Relations Committee, both of the State Medical Association, addressed the sixty Board members attending the meeting. A second form letter and a questionnaire were mailed in January to each Board member and county president stressing the activities to be reported at this general meeting and announcing the convention Board meeting, which was held yesterday, when seventy members of the Board were privileged to hear Dr. Merton M. Minter, San Antonio, member of the Public Relations Committee of the State Medical Association, speak on the public relations program of the Association. I am very grateful to each member of the State Executive Board and to each county president for carrying on the work of the Auxiliary so efficiently and well. It is to them the credit is due for the growth and development of the State Auxiliary this year.

My heart fairly sang with pride when I reviewed the wonderful reports sent to me from all state chairmen, eight council women, and forty-two county presidents. These reports speak for themselves and you shall hear them during this convention.

Please let me take this opportunity to thank the staff of the Texas State Journal of Medicine for their splendid coöperation. The Auxiliary is grateful for the generous space given the State and County Auxiliary reports each month. I deeply appreciate the valuable advice and helpful assistance at all times from Dr. R. B. Anderson and Dr. Holman Taylor. The Auxiliary appreciates Dr. Anderson including the local auxiliary presidents and chairmen at the public relations meetings held over the state by the Medical Association in the interests of a basic science law for Texas. The Auxiliary always stands ready to serve when she is needed.

I also wish to thank Dr. H. F. Connally, State Medical Association President, and Dr. A. B. Pumphrey, our adviser, for their courtesy and willingness to help whenever called upon. Dr. Connally will address the Auxiliary on Wednesday morning.

I cannot close this part of my report without expressing my sincere appreciation to Mrs. Paul Brindley, our gracious hostess president, and to her efficient committee for their most cordial reception. In working out the details of this convention with Mrs. Brindley I have found not only a loyal, capable president but also a delightful new friend.

Organization.—We have emerged from the war years with fifty-four old auxiliaries still intact. This year we have added four new auxiliaries. The total membership of the state is now 2,241. Of this number 78 are members-at-large.

Health Education.—A vital part of the work of the Auxiliary is health education. Believing this starts at home, the Auxiliary has an annual drive for physical check-ups in our own families, starting with the head of the family, the doctor. This year twenty-seven auxiliaries reported 1,857 examinations, 453 of these being doctors. Thirty-one auxiliaries helped with the promotion of *Hygeia* by sending in 764 subscriptions, 289 of these being given to schools and libraries. One of the small county auxiliaries won a third prize on the national *Hygeia* contest. As part of their health program seven auxiliaries had school essay contests, five health films were used, forty-two health talks were made, twenty-eight reviews from the Texas State Journal of Medicine were given, one health institute and one free cancer clinic were held.

Publications.—To keep informed 425 members were monthly readers of the Texas State Journal

of Medicine and 40 members subscribed to the *Bulletin*.

Special Days.—Twenty-four auxiliaries had "Doctors' Day" for their county medical societies with programs of appreciation and entertainment. Thirteen auxiliaries had "Public Relations Day," or meetings open to other organizations to hear health topics discussed by speakers who were authorities on their subjects.

Legislation.—This was perhaps the Auxiliary's most important service this year with twenty-seven county auxiliaries having some type of legislative program. Seventeen auxiliaries helped with the state poll tax campaign. Fifty-three legislative talks were given. Nineteen auxiliaries sent letters to their Congressmen, one writing 130 letters at one time, all of which were answered. Thirteen auxiliaries helped with the distribution of literature, three of these each distributing a thousand pamphlets. When the President of the Auxiliary to the American Medical Association sent word the Y. W. C. A. planned to endorse the Wagner-Murray-Dingell bill at its national convention in March, the delegates from every Y. W. C. A. in Texas were visited and given literature presenting the doctors' stand on this bill.

State Funds.—The Auxiliary maintains four state funds. The Woman's Auxiliary Endowment Fund to assist the Library of the State Medical Association is now $2,400. Of this sum $225 was added this year. The Memorial Fund to assist needy Texas doctors' families is now $7,675. Of this sum $869 was added this year. The Student Loan Fund and the George Plunkett Red Fund are both to assist worthy medical students during the last two years of medical school. The first is now $8,338 with $1,816 added this year. The second is now $4,903.53 with $87 added this year.

County auxiliaries have sent yearbooks to the Archives chairman and their most interesting papers and programs to the chairman of Texas Research for the Southern Medical Auxiliary.

The historian will give the highlights of the year and will present blue ribbon awards at the close of this convention to those county auxiliaries which have done outstanding work for the state and national programs.

Motion was made by Mrs. S. F. Harrington, Dallas, that the President's report be accepted. The motion was seconded and carried.

The President returned to the chair and called for the reports of the officers and chairmen of standing committees.

It was moved by Mrs. S. M. Hill, Dallas, seconded and carried, that the reports of the officers and standing committees be acted on collectively.

Report of President-Elect

As your President-Elect I have had a most enjoyable and profitable year. I have attended two State Executive Board meetings, May 16, 1945, and September 26, 1945, in San Antonio. I also attended the second Conference of State Presidents, Presidents-Elect and National Chairmen of Standing Committees of the Woman's Auxiliary to the American Medical Association, which was held in Chicago December 5 and 6, 1945. This amounts to 8,000 miles of travel. I expect to attend the National Auxiliary meeting in San Francisco, July 1-5, 1945, as your President.

The personal contacts with the women who do the work of our Auxiliary, both national and state, have been most stimulating and the information gained is most useful.

It has been my pleasant duty to appoint the standing committees and council women in the districts where they are not elected. My correspondence, with this finest group of women in our great state, has proven to me by their unselfish willingness to serve in any capacity, that the work of the Woman's Auxiliary to the State Medical Association of Texas will go forward holding up the standards which have been set so high by our most worthy and efficient predecessors. So that we may know the will and be able to coöperate fully with the State Medical Association, I have asked Dr. C. C. Cody, President-Elect of the Association, to speak to the post-convention Executive Board meeting on "A Prospectus for 1946-1947."

I have spent much time studying the various aspects of the organization's work and have read every word pertaining to the Auxiliary in the State June Journals for the past twenty-eight years. In retrospect, the year has been far too short to acquaint and accustom myself to the position I am about to assume. However, it is my earnest desire to fulfill the office of President as capably and efficiently as it has been done these past twenty-eight years. (Mrs. Alexander named me Madame President number twenty-nine.)

I thank all of you for your help and encouragement. Especially, I want to express my love for and appreciation of Mrs. Alexander and her successful year—her untiring personal help and advice. It has truly been a school of instruction for one pupil, the President-Elect.

Mrs. George Turner, El Paso.

Report of First Vice-President—Organization Chairman

The work of organization chairman has been most interesting and educational. We realize the growth of our great medical Auxiliary depends on keeping constantly before us the reasons and the objectives for our organization. Each county president was written a letter asking her to discuss these "reasons" and "objectives" at the first meetings of the year and to ask individual members of the auxiliary to urge the eligible doctors' wives outside the ranks to join with us toward our goal, "Every doctor's wife a member." Personal letters were written to council women and maps were sent showing organized and unorganized counties. Mimeographed copies of "Duties of a Council Woman" and "Method and Procedure of Organizing a County," also a form letter urging doctors' wives where no auxiliary exists to become members-at-large or associate members, were distributed. The fifteen council women this year have made my work a pleasure and they have been most coöperative. To them the credit for this excellent report is due.

District 2.—Mrs. T. D. Young, Roscoe, council woman, reported 2 members-at-large.

District 5.—Mrs. R. H. Crockett, San Antonio, council woman, reported 14 members-at-large.

District 6.—Mrs. P. H. Frenzel, Donna, council woman, helped reorganize Cameron-Willacy Counties Auxiliary, of which Mrs. G. E. Allen, Harlingen, is president.

District 7.—Mrs. T. J. McElhenney, Austin, council woman, and Mrs. Milton C. Williams, San Marcos, reorganized Hays-Blanco Counties Auxiliary. Mrs. McElhenney reported 13 members-at-large.

District 8.—Fayette-Colorado Counties Auxiliary was organized April 30 by Mrs. F. J. L. Blasingame, Wharton. Mrs. R. M. Milner, Yoakum, council woman, reported 13 members-at-large.

District 9.—Mrs. L. L. D. Tuttle, Houston, council woman, reported 11 members-at-large.

District 10.—Mrs. R. C. Bellamy, Daisetta, council woman, organized Orange County Auxiliary with 11 members and 1 member-at-large.

LIBRARY OF THE
COLLEGE OF PHYSICIANS

District 13.—Mrs. E. Roy Townsend, Eastland, council woman, reported 5 members-at-large.

District 14.—Mrs. O. W. Robinson, Paris, council woman, reported 6 members-at-large.

District 15.—Mrs. R. C. Cross, Texarkana, council woman, reported 1 member-at-large.

It was my pleasure to have District 14 meet in my home in December, thirty members attending. Most districts throughout the state have held at least one meeting during the year. This brings us 4 new organizations and 78 members-at-large.

I have received many letters from council women not mentioned in this report who have worked very hard and I feel sure that their good works will bring results later on. I appreciate all of their valuable efforts.

The county presidents report 221 new members for this year. One organization reported 58 new members. The treasurer reports 2,401 paid memberships this year.

I want sincerely to thank our President for her coöperation at all times; she has been most helpful in encouraging organization.

Best wishes to those who take organization responsibilities next year.

Mrs. S. M. Hill, Dallas.

Report of Second Vice-President—Physical Examinations Chairman

The second vice-president of the Woman's Auxiliary to the State Medical Association of Texas, as chairman of physical examinations, wrote letters to the president of each county auxiliary urging her to stress the importance of physical examinations for doctors and their families. The result was a total of 1,857 examinations: 453 doctors, 689 wives, 681 children, and 34 servants.

Mrs. William Janssen, Corpus Christi.

Report of Third Vice-President—Hygeia Chairman

A letter was sent to each auxiliary president in August, 1945, outlining the campaign on, and methods of stimulating the sale of *Hygeia*, and urging the early appointment of a county chairman and containing suggestions for the contest drive which began September 1, 1945, and ended January 31, 1946.

As the names of the county chairmen were sent to me, they in turn were sent to *Hygeia*. A letter of congratulation and encouragement was then written to each chairman, urging each chairman and county president to coöperate to the fullest extent with Mrs. Mark H. Latimer's "Health Hint of the Month" contest.

A note of praise or encouragement was sent approximately every six weeks, which means that about four groups of letters were sent to the fifty-five county auxiliaries.

There were thirty-one county auxiliaries entered in the *Hygeia* contest in the 1945-1946 period. This represents an increase of eight auxiliary groups over the 1944-1945 period.

Total subscription sales for the 1944-1945 period were 662. Total sales for the 1945-1946 period were 764. This is an increase of 102 subscriptions.

One of our auxiliaries, the Childress-Collingsworth-Hall Counties Auxiliary with Mrs. R. E. Clark, Memphis, as chairman, and Mrs. Henry Wilson, Memphis, as president, won third prize of $15 in the Group I (auxiliaries of 1 to 18 members) National Contest sponsored by the American Medical Association for the largest number of *Hygeia* subscriptions sold by auxiliaries.

Mrs. Troy A. Shafer, Harlingen.

HYGEIA SUBSCRIPTION SALES

	Subscriptions	
District 1		
El Paso	50	
District 2		
Dawson-Terry-Lynn-Gaines-Yoakum	0	
Ector-Midland-Martin-Howard-Andrews-Glasscock	4	(3 gift)
District 3		
Childress-Collingsworth-Hall	51	
Lubbock-Crosby	0	
Potter	0	
District 4		
Brown-Comanche-Mills-San Saba	0	
Tom Green-Eight County	4	
Runnels	0	
District 5		
Bexar	23	(11 gift)
Kerr-Kendall-Gillespie-Bandera	26	(5 school; 5 gift)
District 6		
Cameron-Willacy	11	
Hidalgo-Starr	9	
Nucces	50	(1 school; 8 gift)
District 7		
Caldwell	0	
Lampasas-Llano-Burnet	0	
Travis	12	
District 8		
DeWitt-Lavaca	14	
Wharton-Jackson-Fort Bend-Matagorda	0	
District 9		
Austin-Waller	0	
Brazoria	0	
Galveston	8	(4 school; 2 library)
Harris	69	(10 gift)
Walker-Madison-Trinity	0	
Washington	8	(2 gift)
District 10		
Angelina	0	
Hardin-Tyler	3	
Jefferson	26	(7 school; 19 gift)
Liberty-Chambers	19	(2 school; 9 gift)
Nacogdoches	0	
District 11		
Cherokee	0	(2 essays; Health Hint of Month Contest)
Henderson	1	
Smith	6	
Houston-Leon	0	
District 12		
Bell	10	
Brazos-Robertson	0	
Falls	0	
Johnson	2	(1 gift)
McLennan	0	
Erath-Hood-Somervell	0	
District 13		
Baylor-Knox-Haskell	0	
Tarrant	61	(48 school)
Taylor-Jones	15	(1 school; 2 gift)
Wichita	12	(5 school; 7 gift; first prize for January Health Hint of Month Contest)
District 14		
Cooke	0	
Dallas	156	(37 school; 56 gift)
Ellis	2	(2 gift to library)
Grayson	24	
Hunt-Rockwall-Rains	17	(5 school; 7 gift)
Kaufman	0	
Lamar	25	(9 school; 3 gift)
Hopkins-Franklin	2	
District 15		
Bowie-Miller	44	(17 school; 1 library)
Gregg	0	
Harrison	0	
Titus	0	
TOTAL	764	

Report of Fourth Vice-President—Program Chairman

Program planning was initiated early in September with a letter to each county president outlining phases of work to be considered in mapping her year's endeavor. This communication was augmented during the year with cards and letters, including rules for the contest and a complete list of available health films.

For clarity each project as originally outlined shall be reported on separately but briefly.

There is no accurate data on the number of *health institutes* or *forums* held. Some were held with gratifying results. You shall hear about them from the county presidents. Your program chair-

man feels that this is a worthy endeavor and could be expanded.

Health Hint of the Month was an effort to vary the essay contest and to stimulate interest in *Hygeia*. It was not a workable plan. Seven counties participated. Of these, three resorted to one essay on local health problems in order to get school approval. Your fourth vice-president wishes especially to thank those counties which did so much to coöperate on an increasingly difficult endeavor. However, she sent an inquiry to each county president concerning the local school's reaction to such a contest and from the replies cannot recommend the continuance of this policy. In no instance was the school genuinely interested.

The program chairman tried to find out why *health films* are not more generally used. Only five were reported as used by county presidents. Response to the inquiry was not representative enough to be of much value. However, it was noted there was difficulty in arranging for sound track machines and operators. Forty-two *health talks* were reported.

There were 425 JOURNAL *readers*. Cherokee County reported 100 per cent and Dallas County 50 per cent. These were not reported in the above figures. Your chairman was grateful that eleven counties tried a *review* of the Auxiliary Notes in the JOURNAL at county meetings and feels that this method does bring the JOURNAL to more auxiliary members.

Twenty-four counties reported sponsoring a "Doctors' Day." They were, in the main, social meetings with splendid programs on health included in several instances.

Please bear in mind that all the above figures were tabulated from reports of only thirty-six counties.

Most of the counties held monthly meetings and included a social hour (breakfast, lunch, or tea). It would be impractical to list all themes for the year. Some were public relations, legislation, citizenship, fellowship, peace, local health, and new medicines.

Your fourth vice-president has enjoyed this opportunity to work with the State Auxiliary and has thoroughly appreciated this contact with Texas, home, and friends which she left too far away.

MRS. MARK H. LATIMER, Houston.

REPORT OF CORRESPONDING SECRETARY

It has been a privilege and a pleasure to serve the Auxiliary and to work with our most efficient President.

Reservations were taken for the Post Executive Board breakfast given by the President on May 17, 1945. In the absence of the recording secretary I took the minutes of this meeting, which were published in the June, 1945, JOURNAL.

I assisted the President with the compiling and delivery of the stationery, the invitations to the fall and spring Executive Board meetings held in San Antonio and Galveston, respectively, and her letters regarding the year's work and the yearly report. I have written the necessary letters in regard to other phases of the work as requested by the President.

I visited meetings in Galveston, Houston, Austin, and the Tenth District with Mrs. Alexander, and gained much inspiration and knowledge from these splendid meetings.

The President's scrapbook has been compiled and indexed.

I shall be glad to meet with the in-coming corresponding secretary for the school of instruction at the state meeting in Galveston.

MRS. WILBER F. ROBERTSON, San Antonio.

The recording secretary had no report.

REPORT OF PUBLICITY SECRETARY

Your publicity secretary has written letters of instruction to all county and district presidents during the year. She has availed herself of every opportunity to urge that reports be sent to the State JOURNAL.

Approximately 85 communications have been received, including accounts of meetings, social affairs, projects. These reports have been exceptionally well compiled. They have revealed many interesting and worthwhile activities. Only a few districts failed to send some item. Our goal for the next year should be a report of every meeting of every Auxiliary.

MRS. E. L. HOWARD, Fort Worth.

(Read by Mrs. Franklin Campbell, Fort Worth.)

REPORT OF TREASURER

To the President, members of the Executive Board, officers, and members of the Woman's Auxiliary to the State Medical Association of Texas, I wish to take this opportunity to thank you individually and as a group for your assistance and coöperation with my office during my term as treasurer.

The books of the treasurer have been closed and audited for the fiscal year ending May 1, 1946. I submit the following report for your approval, correction, and acceptance.

The financial operations of the Auxiliary show the following balances:

General Fund		
Balance on hand	$ 760.05	
Receipts	1,452.50	
Disbursements	1,183.00	
Total		$1,029.55
Student Loan Fund		
Balance on hand	$6,574.75	
Receipts	1,816.76	
Disbursements	53.06	
Total		$8,338.45
Memorial Fund		
Balance on hand	$ 809.44	
Receipts	869.67	
Disbursements	1,480.00	
Total		$ 199.11
Library Fund		
Balance on hand	$ 175.50	
Receipts	225.25	
Disbursements	175.50	
Total		$ 225.25

In addition to the financial statement, I wish to make the following reports:

County Membership.—The state is divided into fifteen districts. These districts have from one to eight organized auxiliaries. Of these, eight districts reported complete; that is, a report was sent in from all auxiliaries listed in that district. These districts are: District 1, 1 auxiliary; District 3, 3 auxiliaries; District 5, 2 auxiliaries; District 6, 2 auxiliaries; District 8, 2 auxiliaries; District 10, 6 auxiliaries; District 13, 4 auxiliaries; and District 14, 8 auxiliaries.

Two auxiliaries, Orange County in District 10, and Hays-Blanco in District 7, are newly organized this year.

The following counties, identified by their districts, did not report: District 2, Dawson-Lynn-Terry-Gaines-Yoakum; District 4, Runnels (This president did respond, and reported an inactive organization); District 7, Lampasas-Burnet-Llano; District 9, Walker-Madison-Trinity; District 11, Houston-Leon; District 12, Erath-Hood-Somervell; and District 15, Gregg.

From the fifteen districts, we had a total of 2,241 paid auxiliary members.

The lists and dues for these 2,241 members were sent to me by the county treasurers. All of these lists and dues from each county were checked and recorded. The completed list was sent to the national office for its records, and dues of 25 cents for each member were paid. The duplicate lists from the

counties were filed, one with each county treasurer, and one with the state treasurer's files; receipts for all dues were sent to the county treasurer.

In regard to our membership record, let me add that the Woman's Auxiliary has a total of 51 organizations, as compared with 122 for the State Medical Association, giving a percentage of only 41.8. Likewise, the Auxiliary has 2,401 members as compared with 4,603 paid members for the State Medical Association, showing a percentage of only 52.2.

In addition to the above reports on membership, my office likewise compiled a list of all members by districts, and this list was sent to the State Medical Association office for publication in the June JOURNAL. Individual membership cards for all paid members were signed by me, and mailed to the county treasurers for distribution to their members.

Loan Funds.—Each loan fund has a separate chairman, and these chairmen will give their reports on these several funds. The George Plunkett Red Fund and the Library Fund donations are not handled by the treasurer's office, but the operations of the Student Loan Fund and the Memorial Fund are handled through the respective chairmen by the treasurer.

The auditor's report has a record of all loans receivable to the auxiliary in each of the separate loan funds. The amount of money receivable totals $3,867.45 principal, and $676.97 interest, making a grand total of $4,524.42.

All donations and contributions to these funds have been received and posted by me, and an acknowledgement with receipt was sent to each donor.

Likewise, for each payment made on a note, the payments have been credited and acknowledged with receipt by me. During this year, seven notes were paid in full, for a total of $1,084.46 repayment. I have sent to each note debtor a notification by personal letter showing the amounts of principal and interest outstanding.

As retiring treasurer, I wish to recommend:

First, whereas the auditor's report states, "We have examined the notes in your portfolio, and find that most of these notes are worthless, unless immediate action is taken to make collections," and

Whereas my report shows the amount receivable as $4,524.42,

I recommend that the Executive Board consider ways and means of instituting an effective program of collection.

Second, whereas the outdated permanent records and correspondence of the treasurer's office have accumulated for many years, and

Whereas, these records have increased to such proportions that handling and storing has become a problem, and

Whereas, these records are no longer referred to for the active duties of the treasurer,

I recommend that a satisfactory permanent location be designated for the filing of these records.

Third, whereas the State Auxiliary has become such a large organization, with a purpose of increasing the number of its organized auxiliaries, and

Whereas, the amount of money handled through the various functions has reached such great proportions, and that therefore, the duties of the treasurer have become so extensive, and

Whereas, the location of a permanent address for treasurer would be best for correspondence, and for the efficient functioning of the treasuer's office,

I recommend that a person or firm on a part-time basis be employed as permanent treasurer of the Auxiliary; the selection of said person, the salary, and the site of office being subject to the recommendations of the Executive Board.

MRS. F. R. RUGELEY, Wharton.

REPORT OF AUDITOR

May 4, 1946

Mrs. F. R. Rugeley, Treasurer,
Woman's Auxiliary to the
State Medical Association of Texas,
Wharton, Texas.

Dear Mrs. Rugeley:

In accordance with your request, we have audited the records and books of accounts of your association for the fiscal year ending April 30, 1946.

The amounts shown on the copies of each receipt, issued by you, were checked against the entries into the accounts, and the total cash received was checked against the statements of the Wharton Bank & Trust Co. The checks issued by you were examined and an Adjusted Balance was made from the Bank records, and verified by the ledger accounts.

The Cash Balance of $9,754.11 is on deposit in the Wharton Bank & Trust Co., of Wharton, Texas.

We have examined the notes in your portfolio, and find that most of these notes are worthless, unless immediate action would be taken to make collections. The following list of notes are in our opinion worthless and should be cancelled:

Nos. MF61, 30, 1, 2, 25, amounting to $938.38.

The other notes have some possibility of collection, if immediate steps are taken to do so.

We submit herewith the following exhibit and schedules:

Name of Accounts	Balance 5-1-45	Increase	Decrease	Balance 5-1-46
General Fund	$ 760.05	$1,452.50	$1,183.00	$ 1,029.55
Student Loan Fund	6,574.75	1,816.76	53.06	8,338.45
Memorial Fund	809.44	869.67		
Invested in Bonds			1,480.00	199.11
Library Fund	175.50	7.00		
Cash Receivable From Mrs. F. Haggard		218.25	175.50	225.25
Notes Receivable	5,525.13		1,127.24	4,397.89
	$13,844.87	$4,364.18	$4,018.80	$14,190.25

We certify that, in our opinion, the above exhibit and the following supporting schedules represent a true and correct accounting of the Fiscal Year's operation and the financial condition of the Woman's Auxiliary to the State Medical Association of Texas.

Respectfully submitted,
HARRISON & HOLLAND,
Public Accountants.
By ALEX HARRISON.

Statement of Operations

WOMAN'S AUXILIARY
TO THE
STATE MEDICAL ASSOCIATION OF TEXAS
May 1, 1945, to May 1, 1946

Cash Balance May 1, 1945:			
General Fund		$ 760.05	
Student Loan Fund		6,574.75	
Memorial Fund		809.44	
Library Fund		175.50	
Total			$ 8,319.74
Receipts:			
General Fund		1,452.50	
Student Loan Fund		1,816.76	
Memorial Fund		869.67	
Library Fund:			
Deposited by Treasurer	$ 7.00		
In Hands of Mrs. F. Haggard	218.25		
Total Receipts for Library Fund		225.25	
Total			4,364.18

Total Cash Had on Hand for Fiscal Year		12,683.92
Disbursements:		
General Fund	1,183.00	
Student Loan Fund	53.06	
Memorial Fund, Invested in Bonds	1,480.00	
Library Fund	175.50	
Total		2,891.56
Cash Balance May 1, 1946:		
General Fund	1,029.55	
Student Loan Fund	8,338.45	
Memorial Fund	199.11	
Library Fund	7.00	
Cash in Bank	9,574.11	
Cash Receivable, Mrs. F. Haggard (L. F.)	218.25	
Total		$ 9,792.36

General Fund Operations

Cash Balance May 1, 1945:			$ 760.05
Receipts from Auxiliaries:			
District 1	$ .50		
District 2	2.00		
District 3	1.00		
District 5	74.00		
District 7	13.50		
District 8	15.00		
District 9	9.00		
District 13	5.50		
District 14	6.00		
District 15	2.00		
Northwest District	5.50		
Angelina	8.00		
Austin-Waller	3.50		
Baylor-Knox	2.00		
Bell	26.00		
Brown-Mills-San Saba	4.00		
Bexar	143.50		
Bowie-Miller	7.50		
Brazos-Robertson	7.00		
Brazoria	6.50		
Caldwell	4.00		
Cameron-Willacy	9.00		
Cherokee	9.00		
Childress-Collingsworth-Hall	9.00		
Cooke	3.50		
Dallas	182.00		
DeWitt-Lavaca	22.50		
Ellis	8.00		
El Paso	53.50		
Falls	9.00		
Galveston	37.50		
Grayson	12.00		
Hardin-Tyler	5.50		
Harris	175.50		
Harrison	4.50		
Hays-Blanco	6.50		
Henderson	6.50		
Hidalgo-Starr	8.00		
Hopkins-Franklin	23.50		
Hunt-Rockwall-Rains	13.00		
Jefferson	36.00		
Johnson	17.00		
Kaufman	5.00		
Kerr-Kendall-Gillespie-Bandera	13.00		
Lamar	11.50		
Liberty-Chambers	6.00		
Lubbock-Crosby	18.00		
McLennan	14.50		
Nacogdoches	15.00		
Nueces	30.50		
Orange	7.50		
Potter	12.50		
Smith	13.00		
Tarrant	88.50		
Taylor-Jones	20.00		
Titus	2.50		
Tom Green-Eight	6.50		
Travis	50.50		
Washington	11.00		
Wharton-Jackson-Matagorda-Fort Bend	11.50		
Wichita	24.00		
Six County	19.50		
Total Receipts from Dues		$1,377.50	
Refund of President's Expenses (Mrs. Sam E. Thompson)		75.00	
Total Receipts			1,452.50
Total Cash			2,212.55
Disbursements:			
Mrs. Paul H. Power, Expense Fourth Vice-President		10.00	
Returned Check — Mrs. J. L. Pridgen, District 5		17.00	
Returned Check—Hopkins-Franklin		8.00	
Dues to National Treasurer		8.75	
Lodavac Printing Co.—Stationery		65.00	
Returned Check—Johnson County		5.50	
Dues to National Treasurer		564.50	
Luncheon Chairman		3.50	
Mrs. F. R. Rugeley, Treasurer's Expenses		20.00	
Dues to National Treasurer		35.75	
Mrs. C. B. Alexander, President's Expenses		400.00	
Mrs. Mary Elizabeth Power, Secretary's Expense		5.00	
Mrs. W. F. Robertson, Secretary's Expense		5.00	
Harrison & Holland, Auditing		35.00	
Total Disbursements			1,183.00
Cash Balance May 1, 1946			$ 1,029.55

Student Loan Fund Operations

Cash Balance May 1, 1945			$ 6,574.75
Receipts:			
Donations:			
Tom Green-Eight	$ 8.17		
Childress-Collingsworth-Hall	5.00		
Angelina	2.50		
Grayson	1.00		
Harrison	5.00		
Nacogdoches	5.00		
Wharton-Jackson-Matagorda-Fort Bend	4.00		
Bell	17.50		
Liberty-Chambers	2.00		
Harris	25.00		
Nueces	5.00		
Bowie	6.50		
Cherokee	5.00		
Smith	5.00		
Hunt-Rockwall-Rains	2.50		
Taylor-Jones	5.00		
Wichita	10.00		
Austin-Waller	2.00		
Lamar	1.00		
DeWitt-Lavaca	5.00		
Galveston	575.13		
Dallas	25.00		
Washington	10.00		
Total Donations		$ 732.30	
Paid on Notes:			
No.			
5	304.24		
39-48	200.00		
80-89	300.00		
87	100.00		
93	72.06		
Total Paid on Notes		976.30	
Interest Paid:			
No.			
5	34.72		
39-48	16.50		
80-89	45.00		
87	9.00		
93	2.94		
Total Interest Paid		108.16	
Total Receipts			1,816.76
Total Cash			8,391.51
Disbursements:			
Returned Check—Mrs. H. G. W.		25.00	
Returned Check—G. C.		4.00	
Refund to M. F.		24.06	
Total Disbursements			53.06
Cash Balance May 1, 1946			$ 8,338.45

Memorial Fund Operations

Cash Balance May 1, 1945		$ 809.44
Receipts:		
Donations:		
Mrs. E. W. Coyle	$ 12.00	
Mrs. John T. Moore	2.00	
Travis	25.00	
Nacogdoches	5.00	
Six County	5.00	
Wharton-Jackson-Matagorda-Fort Bend	2.00	
Dallas	50.00	
Mrs. P. R. Denman	5.00	
Bexar	38.50	
Kerr-Kendall-Gillespie-Bandera	5.00	

Harris	18.00		
Mrs. C. B. Alexander	5.00		
Liberty-Chambers	2.00		
Dr. J. A. Watts	3.00		
Cherokee	1.00		
Mrs. R. B. Homan	10.00		
Smith	5.00		
Dallas	306.00		
Hunt-Rockwall-Rains	5.00		
Mrs. George Turner	5.00		
Austin-Waller	2.00		
DeWitt-Lavaca	5.00		
Mrs. Mabel E. Alexander	5.00		
El Paso	25.00		
Jefferson	25.00		
Ellis	10.00		
Taylor-Jones	5.00		
Harrison	5.00		
Mrs. J. R. Foster	10.00		
Grayson	3.50		
Tom Green-Eight County	8.17		
Angelina	2.50		
Childress-Collingsworth-Hall	1.00		
Cameron-Willacy	3.00		
Mrs. J. W. Laws	5.00		
Dr. & Mrs. Paul E. McChesney	3.00		
Mrs. C. E. Kitchens	5.00		
Nueces	5.00		
Wharton-Jackson-Matagorda-Fort Bend	2.00		
Total Donations		639.67	
Paid on Notes:			
No.			
8		200.00	
Interest Paid:			
No.			
8		30.00	
Total Receipts			869.67
Total Cash			1,679.11
Disbursements:			
Federal Reserve National Bank of Dallas Bond Series F		740.00	
Federal Reserve National Bank of Dallas Bond Series F		740.00	
Total Disbursements			1,480.00
Cash Balance May 1, 1946			$ 199.11

Library Fund Operations

Cash Balance May 1, 1945			$ 175.50
Receipts:			
Liberty-Chambers	$ 2.00		
Six County	5.00		
Total Receipts Deposited by Treasurer		7.00	
Received by Mrs. F. Haggard:			
Austin	2.00		
Bexar	100.00		
Mrs. C. B. Alexander, State President	25.00		
Dallas	25.00		
Hunt-Rockwall-Rains	2.50		
Kerr-Kendall-Gillespie-Bandera, Savings Bond, Memorial to Dr. J. D. Jackson, Kerrville	18.75		
Dr. and Mrs. Sam E. Thompson, Kerrville, Memorial to Dr. J. D. Jackson, Kerrville; Dr. Stirling Russ, San Antonio	20.00		
Liberty-Chambers	2.00		
Nueces	5.00		
Smith	3.00		
Harris	10.00		
Taylor-Jones, Memorial to Mrs. J. M. Alexander, Mrs. W. R. Snow, Abilene	5.00		
Total Received by Mrs. F. Haggard		218.25	
Total Receipts			225.25
Total Cash			400.75
Disbursements:			
Dr. R. B. Anderson, Librarian, Texas Memorial Medical Library Association			175.50
Cash Balance May 1, 1946:			
Deposited by Treasury		7.00	
Received by Mrs. F. Haggard		218.25	
Total			$ 225.25

Notes Receivable

Note Number	Balance 5-1-45	Increase	Decrease	Balance 5-1-46	Interest Received
49	$ 100.00			$ 100.00	
78	100.00			100.00	
M. F. 61	250.00			250.00	
30	463.38			463.38	
1	175.00			175.00	
2	50.00			50.00	
25	50.00			50.00	
69	28.75			28.75	
70	50.00			50.00	
71	50.00			50.00	
72	50.00			50.00	
73	50.00			50.00	
47	100.00			100.00	
51	100.00			100.00	
35	105.70			105.70	
77	100.00			100.00	
93	48.00		$ 48.00		$ 2.94
94	100.00			100.00	
37	96.25			96.25	
36	175.00			175.00	
57	100.00			100.00	
15	127.55			127.55	
M. F. 16	338.31			338.31	
17	124.94			124.94	
98	100.00			100.00	
13	138.45			138.45	
13 A	100.00			100.00	
13 B	100.00			100.00	
39	100.00		100.00	0.00	6.00
48	100.00		100.00	0.00	10.50
M. F. 8	200.00		200.00	0.00	30.00
11	125.00			125.00	
45	193.66			193.66	
53	100.00			100.00	
58	150.00			150.00	
92	100.00			100.00	
90	100.00		100.00	0.00	
80	100.00		100.00	0.00	45.00
89	100.00		100.00	0.00	
5	304.14		279.24	24.90	34.72
XVI	75.00			75.00	
59	150.00			150.00	
81	150.00			150.00	
—	6.00			6.00	
87	100.00		100.00	0.00	9.00
	$5,525.13		$1,127.24	$4,397.89	$ 138.16

The parliamentarian had no report.

Report of Legislative Committee

The legislative committees of the medical auxiliaries throughout the state of Texas have accomplished much this year. Each county report will recount its own endeavors. We have been successful in most instances, but the battle against socialized medicine is now in its crucial stage. Our Congress is now having hearings on a bill to socialize medicine (Wagner-Murray-Dingell); much of these hearings is not on our side. All of which means we must strive harder to inform the public of the evils of this bill.

There have been many public meetings sponsored by the county organizations. We have no way of finding out how many letters were written to our Congressmen but the more the better. Please stress that to everybody to whom you speak. Personal calls on Congressmen is the very best approach. England under socialized medicine had 12 per cent more men rejected by the armed forces than we had under private practice.

We have accomplished two other noteworthy results. The poll tax campaign was carried out to influence our own members and our friends to pay their poll taxes this year. People who want votes usually cater to those who vote. The other success which we got through exerting our influence over representatives over the state was the withdrawing from the agenda of the national Y. W. C. A. the sponsorship of the Wagner-Murray-Dingell bill.

Outstanding reports are from El Paso, Cherokee, Angelina, Dallas, Harris, Bexar, Bowie-Miller, Hunt-Rockwall-Rains, Taylor-Jones, Galveston, Liberty-Chambers, and Falls Counties. There were many

other favorable reports, but I am sure we could all do better.

Now as to the future—it is imperative that we elect, in July, legislators in our state and national government who have a proper attitude toward public health and medical legislation. We are to work under the supervision of county medical societies, but sometimes we may help by urging our doctors to work on these matters. Please appoint in your local organization one of your best workers to this tremendous task for next year. Now we must be prepared and accept our obligation.

I have on hand a letter from the State Medical Association stating the stand of the national representatives and the state legislators. It seems that our two U. S. Senators are for us. Also most of our Representatives. We do not know how their opponents stand. So from that it is safe for us to reelect them. There are several who are not candidates for reëlection—Sumners of Dallas, Johnson of Corsicana, Russell of Stephenville, and Lanham of Fort Worth. So in their places we must find someone who is our friend. The medical society will do this, but we must influence people to vote for the proper candidate.

MRS. A. B. PUMPHREY, Fort Worth.

REPORT OF PUBLIC RELATIONS CHAIRMAN

In February, the work begun by Mrs. W. R. Snow, Abilene (deceased), was continued by the present chairman.

Letters were sent to each county president urging coöperation with the State Medical Association in its opposition to the Wagner-Murray-Dingell bill, which would socialize medicine, and the Pepper bill for child and maternal welfare, another socialistic bill.

Suggestions for a comprehensive and effective public relations program were outlined also. These letters were of course to be given to county public relations chairmen.

Pamphlets from Dr. W. W. Bauer, Director, Bureau of Health Education for the American Medical Association, announcing the national radio programs on "Doctors at Home" were mailed.

Letters from out-of-state inquirers for information were referred to the State Medical Association office. Pamphlets were mailed from there direct.

County projects included many activities such as public relations programs, coöperation with various local organizations, junior leagues, youth organizations, Red Cross, hospitals, infantile paralysis, social service organizations, and various other local groups. Several auxiliaries aided in the campaigns locally to have each citizen pay his poll tax. In addition, many hours were spent in war work and drives.

MRS. W. FRANK ARMSTRONG, Fort Worth.

REPORT OF LIBRARY FUND CHAIRMAN

The State Medical Association of Texas about ten years ago initiated the package library service to physicians of Texas, a set-up in the State Library at Fort Worth. Any reputable doctor can secure a library package of the latest literature on any subject in medicine, which saves him many hours of valuable time.

On July 30, 1940, Dr. Sam E. Thompson, Kerrville, established the first endowment fund of $1,000, which is known as the "Dr. and Mrs. Sam E. Thompson Memorial Fund." Since then, other doctors or their families have contributed a similar amount as memorials. The principal of these endowment funds will remain forever intact, and only the revenue derived therefrom will be expended in support of the financial operations of the Library. Here is an opportunity not only for doctors and doctors' wives to advance the cause of scientific medicine in Texas, but to perpetuate the memories of their loved ones in a great cause.

At the suggestion of the Board of Trustees of the Association three years ago the State Medical Auxiliary added the Library Fund as another project to its many worthy causes. The amount of your contribution as an individual or as an auxiliary, large or small, will be beneficial. There is nothing that the Woman's Auxiliary to the State Medical Association can do that will be as helpful in the advancement of scientific medicine in Texas as to sponsor and secure endowments for the Library of the Association to which you are an Auxiliary.

Counties and individuals contributing to this fund this year follow:

Austin County, Sealy	$ 2.00
Bexar County	
San Antonio	100.00
Mrs. Charles B. Alexander, San Antonio, State President	25.00
Dallas County, Dallas	25.00
Hunt-Rockwall-Rains Counties, Greenville	2.50
Kerr-Kendall-Gillespie-Bandera Counties	
Kerrville (Savings bond, memorial to Dr. J. D. Jackson, Kerrville)	18.75
Dr. and Mrs. Sam E. Thompson, Kerrville (Memorial to Dr. J. D. Jackson, Kerrville, and Dr. Stirling Russ, San Antonio)	20.00
Mrs. Earl Gregg, Kerrville (Memorial to Mrs. J. S. Whitwood. Harper)	5.00
Liberty-Chambers Counties, Hull	2.00
Nueces County, Corpus Christi	5.00
Smith County, Tyler	3.00
Harris County, Houston	10.00
Taylor-Jones Counties, Abilene (Memorial to Mrs. J. M. Alexander and Mrs. W. R. Snow, Abilene)	5.00
Wharton-Jackson-Matagorda-Fort Bend Counties	2.00
TOTAL	$225.25

MRS. FRANK HAGGARD, San Antonio.

The President declared the session recessed until 9:00 o'clock Wednesday morning. The session recessed at 12:15 p. m.

MRS. WILBER F. ROBERTSON, San Antonio,
Recording Secretary.

SECOND GENERAL MEETING

At 9:00 a. m., Wednesday, May 8, 1946, in the Solarium of the Buccaneer Hotel, Galveston, the twenty-eighth annual session of the Woman's Auxiliary to the State Medical Association of Texas reconvened in the second business meeting.

Mrs. Charles B. Alexander, President, called the meeting to order.

Communications were called for and telegrams of greetings to Mrs. Charles B. Alexander, President, and congratulations to Mrs. George Turner, President-Elect, from Mrs. Mark H. Latimer, Houston, fourth vice-president, were read.

Minutes of the general meeting of the previous day were read and approved.

The President introduced Dr. H. F. Connally, Waco, President of the State Medical Association, guest speaker. The introduction and address follow.

INTRODUCTION OF DR. H. F. CONNALLY

It gives me great pleasure to present Dr. Herschel Frank Connally, the eightieth President of the State Medical Association of Texas. Dr. Connally is a native Texan. During World War I he was a lieutenant colonel in command of a base hospital in France. In his home city of Waco, Dr. Connally has served on the board of directors of the Chamber of Commerce and of the Rotary Club and has been mayor of the city of Waco. Dr. Connally served fifteen years on the Texas State Board of Medical Examiners and eight years as chairman of the Reciprocity Committee. As eightieth President of the State Medical Association, Dr. Connally has rendered a double service to the doctors of Texas, for the war necessitated his remaining in office a second term. May we express to you, Dr. Connally, our sincere appreciation for the valuable time and earnest effort you have expended in the interest of our husbands, the doctors of Texas.

Address of Dr. H. F. Connally

It is very gratifying, and yet very challenging, to me to meet with this fine group of enthusiastic women—gratifying, because I am fully conscious of the fact that I have the wholehearted support of your organization in making this meeting in Galveston a complete success; challenging, because I realize that it will be a real task for me to furnish the leadership necessary to develop this meeting into one as great as will be necessary to cover the ground work which you have so well laid out for us in the two years since we last met in Dallas.

It has not been my privilege to meet with your State Committee or Executive Council during President Alexander's administration. Circumstances were such that made it impossible for me to be present at your Council meeting in San Antonio last May.

Our district meetings, as well as our state meetings, were not convened during last year; consequently, we did not have the opportunity either to plan or to hold a meeting that would enable us to carry out any plans that we may have had in our minds.

We were all interested in defeating the national political socialized medical program of 1944. The splendid work of this Auxiliary had more to do with the formation of such a solid front line of defense by our Congressmen and Senators than did the efforts of the doctors themselves. The personal letters and postcards you sent to the Congressmen had a very decided effect on their stand against the bill. Your work in educating the public was far-reaching; your public relations work was very outstanding, all of which was very helpful to the Congressmen in making up their minds to vote against the bill that was then up for consideration in Congress.

My meeting with your Council in Kerrville in 1944, which was during Mrs. Sam Thompson's term of office as President, gave me an insight into the work you had outlined, and established my confidence and respect for your ability to make workable plans and carry them to a successful conclusion.

We have the highest praise for what you have accomplished in the recent past, and we know you are fully aware of the danger that confronts our honored profession in the strong threat contained in the present Wagner-Murray-Dingell bill (S. 1606) that is now before the Committee on Education and Labor of the United States Senate. We know that you are going to give your best in coöperation with the fine leadership of the National Physicians Committee and the State Medical Association of Texas to defeat this vicious piece of legislation that is now confronting us.

When the defeat of this bill has been accomplished, we will have new fields to prepare. There will be some changes sought in the Texas Medical Practice Act which at this time appear advisable, if not really necessary. The ground work for these changes will be planned at this meeting. It is my earnest desire that the changes will be worked out by those who have knowledge of the conditions in this state, as well as the majority of other states in the union, and that they will be able to arrive at an intelligent comparison between what we now have and what the conditions in Texas now demand. There are many things to be considered in changing the laws of our state governing the practice of medicine. These changes should be planned by those who are capable of sound thinking and of acting without prejudice toward any group.

Another program this organization should support is the effort that is now being made by the profession at Dallas and Houston to raise the standard of medical education in Texas by establishing great medical centers in those two cities. When these centers are completed, they will furnish our boys who are studying medicine the advantages necessary for them to complete their medical education and obtain the postgraduate training that will develop them into specialists, without having to leave Texas. It is our duty to see that boys who desire to take their medical training in the University of Texas get the clinical advantages that are necessary to develop them to the fullest capacity in their junior and senior years. To do that will require some drastic changes in the School of Medicine at Galveston, which changes should be sponsored by the State Medical Association of Texas and this Auxiliary.

It is particularly fitting for your Auxiliary to become interested in this program, for many of you will have sons who will want to get their medical education at the University of Texas. If the University of Texas develops into a school that is capable of giving a finished medical education to its graduates, and prepare for an expanded postgraduate program, it will be necessary for the school to have a very decided increase in the volume of its clinical material. Last, but not least, among the work of the State Medical Association in which I am asking your coöperation is that of our medical library in Fort Worth. Everyone is interested in this program, but all of us are not giving especial attention to the growth of our library. There is a field of work in the further development of our library that you ladies can successfully carry out. I believe that the library work generally is more appealing to ladies than to men, and you will do a great deal toward keeping up the general interest in the library by taking on the leadership.

The President resumed the unfinished business of the previous day, and the reports of the following standing committee chairmen were given:

Report of Memorial Fund Chairman

It has been my pleasure to serve again as chairman of the Memorial Fund of the Texas State Medical Auxiliary. Mrs. Joe B. Foster, Houston, and Mrs. S. F. Harrington, Dallas, have served with me. We had one committee meeting, several conferences, and much correspondence. The present policy of collecting funds and investing in bonds will be continued.

For the benefit of the new members I shall repeat: The Memorial Fund was created as a means to provide financial aid to indigent doctors or their families. It accumulates by voluntary contributions from medical organizations and from individuals who contribute directly or who send memorial cards instead of flowers to convey love and sympathy. The donations are retained as perpetual memorials, but the interest therefrom is to be used at the discretion of the committee.

We are happy to report the purchase of two more $1,000 bonds since last May, bringing our total to ten, besides one $25 bond. We actually have in the Federal Reserve National Bank an investment of $7,418.75 and a cash balance of $257.11. There were no disbursements this year and one loan was returned. I am very grateful for such a good report.

There is one amount I wish to register indelibly in your mind—it is not the amount we have, or what we have collected, or what has been returned. It is the amount we *need*. When our principal reaches $10,000 the interest therefrom will be sufficient for at least one love gift a year. The difference between what we have in the bank and what we need is $2,324.14. That is the amount to keep in mind. We can cut it down materially this year if every auxiliary will donate, and those that give regularly will raise the amount of their gift. If you have been giving $2, try to make it $3. If you gave $10, thanks a lot, but would $15 be asking too much? One of the auxiliaries made a big advance this year. It was

our hostess auxiliary. I am so proud of Galveston sending $58. Six county auxiliaries gave $25 or more and several small auxiliaries gave even more in proportion. On the other hand there are many auxiliaries that have never had any part in this wonderful work. My thought is why would every one not be glad to contribute. It is such a suitable channel for outwardly expressing one's inner feelings and for reflecting the lasting influence of sweet and blessed memories.

"We may not know or understand
Why some must have a helping hand
But if we have it's nice to share
And help another avoid a snare."

MRS. O. M. MARCHMAN, Dallas.

REPORT OF STUDENT LOAN FUND COMMITTEE

The Student Loan Fund Committee reports good collections during the war, and when the students need help from now on, let us be found with "our lamps trimmed and burning."

"It isn't the cut of the clothes you wear
Nor the stuff out of which they are made,
Though chosen with taste and fastidious care,
And it isn't the price you paid.
It isn't the size of your pile in the bank,
Nor the number of acres you own.
It isn't a question of prestige or rank,
Nor sinew and muscle and bone.
It isn't the servants that come at your call.
It isn't the things you possess,
Whether many or little or nothing at all.
It's SERVICE that means success."

MRS. JOHN T. MOORE, Houston;
MRS. WILLARD COOKE, Galveston;
MRS. M. L. GRAVES, Houston.

REPORT OF CHAIRMAN OF GEORGE PLUNKETT RED SCHOLARSHIP FUND

I attended the Executive Board meeting in San Antonio in September. I have written sixty-five letters. I have received and deposited with the Trust Department of South Texas Commercial National Bank the following gifts:

Harris County Medical Auxiliary	$25.00
Mrs. Kathryn Red Parker	14.00
Hunt-Rockwall-Rains Counties	2.50
Austin-Waller Counties	2.00
Paris Auxiliary	1.00
Taylor-Jones Counties	5.00
Liberty-Chambers Counties	2.00
Angelina County	2.50
Nueces County	5.00
Sale of Books	7.00
Childress-Collingsworth-Hall Counties (Hattie Hunt Auxiliary)	1.00
Bexar County	20.00
Total	$87.00

Report From Trust Department

Government Bonds	$3,000.00
Outstanding Notes	685.83
Savings Account	638.39
Cash	579.31
Book Value as of March 1, 1946	$4,903.53

MRS. WILLIAM E. RAMSEY, Houston.

REPORT OF REVISIONS COMMITTEE

No revisions of the Constitution and By-Laws of the Woman's Auxiliary to the State Medical Association have been made this year. One recommendation came too late to be acted upon at the annual meeting. This recommendation will be submitted to the Executive Board which meets in the fall and will come up for final action at the 1947 annual meeting.

The proposed amendment to Article 5, Sec. (a) of the Constitution, pertaining to Board members, follows: "Whereas the presidents of auxiliaries to the County Medical Societies have always been ex-officio members of the Executive Board of the Woman's Auxiliary to the State Medical Association, and whereas they are vitally interested in and actively engaged in promoting the aims of organization, be it resolved that they be made official members of the Executive Board."

All amendments to the Constitution and By-Laws which have been made since 1942 will be incorporated in the new edition of the Constitution and sent to each county auxiliary as soon as it is off the press. The Revisions Committee recommends that the Constitution and By-Laws be read before each auxiliary that all members may know the aims and policies of the Auxiliary.

MRS. R. B. HOMAN, El Paso;
MRS. J. FRANK CLARK, Georgetown;
MRS. RAMSAY H. MOORE, Dallas.

REPORT OF ARCHIVES CHAIRMAN

As a preface to my fourteenth annual report I am happy to record the cessation of war preparations and the return of many of our medical men from all parts of the world. This means that our local auxiliaries are getting somewhat back to normal.

Local programs are being colored by news from the battle fields. This is all absorbing since our doctors were in the thick of the fight. Yet we pray it may never happen again.

Among the many interesting items to be found in the monthly Auxiliary Notes, local auxiliaries are following with interest the itinerary of our President, Mrs. Charles B. Alexander. This means a new interest in local work all along the line.

We are happy in the thought of a good old fashioned annual meeting in Galveston again—"full dress," "riding the waves," and all the other trimmings thrown in.

Two historical reports have recently been received: the administration of Mrs. S. F. Harrington, 1941-1942, from Mrs. Sam E. Thompson, Kerrville; also Mrs. S. E. Thompson, 1944-1945, from Mrs. Marvin Duckworth, Cuero.

Please send more yearbooks.

Do not fail to let all printed matter carry exact dates.

MRS. W. A. WOOD, Waco.

REPORT OF TEXAS RESEARCH TO SOUTHERN MEDICAL AUXILIARY

Last October letters were sent to all county and district presidents requesting papers pertinent to our Auxiliary interests. The same appeal was made in person at the State Executive Board meeting in September. Pressure of war activities had curtailed sending papers to your research chairman during the past few years but as peace reigns again, interest is renewed and your chairman is glad to report the following articles have been received: (1) "Obstetrics in the Post War Years," Dr. Allen T. Stewart, Lubbock; (2) "Is Socialism Coming to Texas?" State Medical Association Public Relations Committee; (3) "Memorial Address," Mrs. P. R. Denman, Houston (sent by a friend); (4) Brief history and pictures of "The Medical School of the University of Texas," Rosella H. Werlin; (5) "Address," Mrs. C. B. Alexander, San Antonio, President, Woman's Auxiliary to the State Medical Association of Texas; (6) "History of Texas Medicine," Dr. A. O. Singleton, Galveston; (7) "Installation Service," Mrs. G. V. Brindley, Temple.

MRS. E. H. MAREK, Yoakum.

The *Bulletin* chairman, Mrs. Cecil O. Patterson, Dallas, reported thirty-four subscriptions.

Report of Budget Committee

The following budget for 1945-1946 was approved and adopted by the Executive Board in May, 1945:

President's expenses	$ 400.00
First Vice-President	15.00
Fourth Vice-President	10.00
Recording Secretary	10.00
Treasurer	10.00
Auditor	35.00
Stationery	65.00
Membership list (typing)	5.00
Essay awards	35.00
A. M. A. dues	594.00
	$1,179.00

Mrs. William Hibbitts, Texarkana, Chairman;
Mrs. E. C. Ferguson, Beaumont;
Mrs. Walter Minsch, San Antonio.

Report of Memorial Committee

Letters were written to all county presidents and to the council women of the fifteen districts asking for names of deceased members of the year.

Nine of our beloved members were reported as having passed "into the undiscovered country from whose bourn no traveler returns." The families of these have been written letters of sympathy and asked to be present at the memorial services to be held at the Hotel Galvez, Wednesday, May 8, 1946, at 5:15 p. m. The list of deceased members has been sent to the *National Bulletin* and appears in an account of Memorial Services in this issue of the Journal (pages 237-238).

The committee gratefully appreciates the assistance of our State President, Mrs. Charles B. Alexander, the auxiliary presidents, and council women.

Mrs. P. R. Denman, Houston, Chairman;
Mrs. Marvin Duckworth, Cuero;
Mrs. A. J. Streit, Amarillo.

Report of Advisory Committee Chairman

As chairman of the Advisory Committee I have no detailed report to make. During the year our President, Mrs. Charles B. Alexander, and I have had many talks and informal discussions regarding the work of the Auxiliary. It has been a pleasure as well as a privilege to serve this year with Mrs. Alexander.

Mrs. Scott C. Applewhite, San Antonio.

Mrs. W. R. Thompson, Fort Worth, moved that the reports be accepted; the motion was seconded by Mrs. Scott C. Applewhite, San Antonio, and carried.

Mrs. S. H. Watson, Reference Committee chairman, made the motion that the following suggestions be thoroughly investigated and presented at the fall Board meeting:

1. That the treasurer's records, except the current ones held by the treasurer, be kept in a permanent location, preferably Fort Worth.
2. That the expense account of the treasurer be increased to allow necessary assistance.
3. That the Auxiliary's "Notes Receivable" be brought up to date, a list of the debtors being presented to the Auxiliary.
4. That the county presidents be made members of the Board, and, further, that the Executive Board luncheons be "no host" affairs relieving the President of this expense.

The motion was seconded and carried.

The President called for the reports of council women and county presidents. Mrs. Scott C. Applewhite, San Antonio, moved that the reports be acted on collectively. The motion was seconded and carried.

The following reports were given:

Report of Second District Council Woman

There was no district meeting this year, as the Six-County Auxiliary is still the only one functioning.

Numerous telephone calls were made and letters written in the interest of organization work, membership-at-large, and against the proposed legislation for socialized medicine. I made two talks before civic and study clubs concerning socialized medicine and have another one scheduled.

As soon as peacetime readjustments are made by the families of doctors who have returned from the service, there should be excellent opportunities for organization and re-activating work in this district.

Mrs. T. D. Young, Roscoe.

Report of Seventh District Council Woman

Nineteen letters were written to wives who were members-at-large urging them to become organized and offering to meet with them for that purpose. All 1945 members-at-large were sent invitations to attend the February luncheon for Mrs. Alexander. Dues for membership-at-large were received from thirteen members in response to a plea to send in dues before April 1. In all, forty-one letters were written and various explanations for failing to organize were received.

Mrs. T. J. McElhenney, Austin.

Report of Eighth District Council Woman

As council woman of District 8, I am happy to report our response of nonmembers of unorganized counties was exceedingly good. Thirty-two letters were sent to the nonmembers inviting them to become associate members. Thirteen responded promptly. We have twenty-five active members.

Mrs. R. M. Milner, Yoakum.

Report of Ninth District Council Woman

Your council woman from District 9 has written thirty-five letters to doctors' wives in six unorganized counties urging these counties to organize or to send in dues of $1 as associate members to the State Auxiliary. Nine ladies have sent in dues as associate members.

Your council woman has attended all meetings of the South Texas District, all meetings of the Harris County Auxiliary, a games party given by the Galveston County Auxiliary, and the health institute sponsored by the Harris County Auxiliary, which was outstanding as a health education project.

Your council woman is serving on the arrangements committee for the council woman's luncheon and school of instruction to be held at the state meeting in Galveston.

She has written twelve letters and cards urging opposition to the Wagner-Murray-Dingell and Pepper bills; also worked actively in the poll tax campaign. She has also asked the county auxiliaries to work and write to help defeat these bills.

Your council woman, in her correspondence with county groups, has urged them to remember our four benevolent funds, our Library Fund, Student Loan Funds (two), and the Memorial Fund.

It has been a pleasure and a privilege to work with this fine group of officers and women to try to carry out the plans and work as suggested by our State Medical Association.

Mrs. L. L. D. Tuttle, Houston.

Report of Tenth District Council Woman

District 10 is composed of fifteen counties, representing ten medical societies. There are five organized and five unorganized auxiliaries.

Eighty-six letters were written to the presidents of the medical societies and wives in unorganized areas. Four long distance calls were made and 126 miles traveled.

February 20, Mrs. E. R. Richter, Dayton, and I drove to Orange and organized an auxiliary in the home of Mrs. Leo J. Peters. Organization was aided

by Mrs. C. E. Phillips, who contacted the ladies for meeting. There are eleven members in this auxiliary, and officers are president, Mrs. T. O. Woolley; vice-president Mrs. Leo J. Peters; secretary-treasurer, Mrs. J. V. Smith; parliamentarian, Mrs. George Y. Swickard.

Effort was made to create interest for organization in remaining counties but to no avail.

I have attended all State Executive Board meetings.

The only dues received for members-at-large were from Mrs. Thomas L. Hurst, Center, and Mrs. L. S. Oates, Center.

The South Texas District Auxiliary, composed of Districts 8, 9, and 10, with 654 members, met in Houston November 18. We were honored to have our lovely State President with us at that time.

April 17, our first real postwar meeting was held in Brenham with record attendance and excellent reports from the counties.

Reports showed 895 physical examinations, $955 contributed to the four auxiliary funds and outside activities, 155 *Hygeia* subscriptions, health talks given and legislative measures combated by educating the laity and correspondence with representatives in Congress.

It has been a pleasure to serve as council woman for the State Auxiliary and presiding officer of the South Texas District Auxiliary.

To my successor I extend very best wishes.

Mrs. Richard C. Bellamy, Daisetta.

Report of Eleventh District Council Woman

Officers of the Woman's Auxiliary to the Eleventh District Medical Society for 1946-1947 are as follows: president, Mrs. George M. Hilliard, Jacksonville; first vice-president, Mrs. J. L. Dean, Crockett; second vice-president, Mrs. C. B. Young, Tyler; third vice-president, Mrs. A. L. Kuykendall, Rusk; recording secretary-treasurer, Mrs. J. M. Travis, Jacksonville.

The Eleventh District Auxiliary met twice with an average attendance of thirty.

The report of the county presidents at the spring meeting showed an increased attendance in all auxiliaries except one. As our young doctors return from military service we hope to have larger and better auxiliaries next year. All counties are organized except two and we hope to have active auxiliaries there by fall.

Mrs. L. B. Windham, Tyler.

Report of Fourteenth District Council Woman

Membership of District 14 is as follows: *Members*, Gainesville, Cook County, 7; Dallas, Dallas County, 371; Waxahachie, Ellis County, 16; Denison and Sherman, Grayson County, 25; Mt. Vernon and Sulphur Springs, Hopkins-Franklin Counties, 16; Commerce and Greenville, Hunt-Rockwall-Rains Counties, 31; Terrell, Kaufman County, 15; Paris, Lamar County, 23; Total, 504. *Members-at-large*, Cooper, Delta County, 2; Denton, Denton County, 2; Bonham, Fannin County, 2; Total, 6. Grand Total, 510.

The regular meeting of the Fourteenth District Medical Society to have been held in June, 1945, was not held because of war, and hence the auxiliary did not meet.

The Woman's Auxiliary to the Fourteenth District Medical Society met in regular session December 11, 1945, at the home of Mrs. S. M. Hill, Dallas. A fair representation of the county auxiliary members was present to enjoy the luncheon in Mrs. Hill's lovely home, Christmas decorations being used throughout the rooms. It was not possible for the State President to be with us, but Mrs. O. M. Marchman, Dallas, gave a most comprehensive discussion on the Wagner-Murray-Dingell bill, and urged all members to acquaint themselves with the bill and to encourage the laity to write to their Congressmen in opposition to it. Routine business was attended to, and the report of the nominating committee, consisting of Mrs. S. H. Watson, Waxahachie, chairman; Mrs. R. S. Usry, Dallas, and Mrs. S. B. Longino, Sulphur Springs, was given and the following officers were elected for 1946-1947: Mrs. O. W. Robinson, Paris, president; Mrs. Earl Stirling, Sulphur Springs, vice-president; Mrs. Leslie Moore, Dallas, secretary-treasurer. Announcement was made that the next meeting of the Auxiliary will be held in June, 1946, at Gainesville. The meeting was adjourned by Mrs. Robinson.

During the past year there were eighty-seven letters and thirty-two postal cards mailed to members. Trips were made to Cooper, Bonham, Denton, Mineola, and Winnsboro in behalf of the District 14 Auxiliary. All dues pertaining to the district have been paid.

Mrs. O. W. Robinson, Paris.

Report of Fifteenth District Council Woman

The Northeast District has not met since the "Duration," so many of the doctors being in service. The women of this district have joint sessions when the doctors meet.

Our membership is still the same as in 1943, with one new member-at-large, Mrs. Mary Fuller, Shiner. Communications regarding current state legislation of interest to the medical profession were sent by mail and wire.

With so many young doctors back and again in practice, we hope to increase our membership and are looking forward to meeting with the doctors in the near future.

Mrs. Ralph Cross, Texarkana.

Reports of county presidents were read as follows: El Paso, Mrs. Robert F. Thompson, El Paso; Ector-Midland-Martin-Howard-Andrews-Glasscock, Mrs. James H. Chapple, Midland; Potter, Mrs. D. S. Marsalis, Amarillo; Brown-Comanche-Mills-San Saba, Mrs. J. M. Campbell, Goldthwaite; Tom Green-Eight County, Mrs. R. M. Finks, San Angelo; Bexar, Mrs. Frank Steed, San Antonio (read by Mrs. T. A. Pressly, San Antonio); Kerr-Kendall-Gillespie-Bandera, Mrs. W. E. Gregg, Kerrville, (read by Mrs. Sam Thompson, Kerrville); Cameron-Willacy, Mrs. G. E. Allen, Harlingen; Hidalgo-Starr, Mrs. Noel Ice, McAllen; Nueces, Mrs. J. F. Pilcher, Corpus Christi (read by Mrs. J. F. Campbell); Caldwell, Mrs. J. T. O'Banion, Luling; Lampasas-Llano-Burnet, Mrs. Joe A. Shepperd, Burnet; Travis, Mrs. John A. Crockett, Austin; DeWitt-Lavaca, Mrs. Gillette Burns, Cuero (informal report by Mrs. E. H. Marek, Yoakum); Wharton-Jackson-Matagorda-Fort Bend, Mrs. F. J. L. Blasingame, Wharton; Austin-Waller, Mrs. O. E. Steck, Bellville; Brazoria, Mrs. Walter E. Cox, Angleton; Galveston, Mrs. Paul Brindley, Galveston; Harris, Mrs. A. N. Boyd, Houston; Washington, Mrs. C. E. Southern, Burton; Angelina, Mrs. M. O. Gibson, Lufkin; Hardin-Tyler, Mrs. W. J. Poshataske, Silsbee; Jefferson, Mrs. John H. Carter, Beaumont; Liberty-Chambers, Mrs. A. L. Delaney, Liberty (read by Mrs. R. C. Bellamy, Daisetta); Nacogdoches, Mrs. Stephen B. Tucker, Nacogdoches; Orange, informal report by Mrs. R. C. Bellamy, Daisetta; Cherokee, Mrs. R. T. Travis, Jacksonville; Henderson, Mrs. R. E. Henderson, Athens; Smith, Mrs. C. B. Young, Tyler; Bell, Mrs. J. R. Winston, Temple; Brazos-Robertson, Mrs. S. C. Richardson, Bryan; Falls, Mrs. A. M. Hutchings, Marlin; Johnson, Mrs. T. F. Yater, Cleburne; McLennan, Mrs. H. M. Anspach, Waco; Tarrant, Mrs. A. L. Roberts, Fort Worth; Taylor-Jones, Mrs. L. W. Hollis, Jr., Abilene; Wichita, Mrs. H. P. Ledford, Wichita Falls; Dallas, Mrs. J. H. McCracken, Dallas; Ellis, Mrs. S. H. Watson, Waxahachie; Grayson, Mrs. W. A. Lee, Denison; Hunt-Rockwall-Rains,

Mrs. B. F. Arnold, Greenville; Kaufman, Mrs. R. C. Sloan, Terrell; Lamar, Mrs. R. L. Lewis, Paris; Bowie-Miller, Mrs. William Hibbitts, Texarkana; Harrison, Mrs. F. S. Littlejohn, Marshall.

Mrs. Paul Brindley, Galveston, moved that the reports be accepted; the motion was seconded by Mrs. S. M. Hill, Dallas, and carried.

The President declared the meeting recessed until 1:00 p. m. for luncheon. The meeting recessed at 11:45 a. m.

MRS. WILBER F. ROBERTSON, San Antonio,
Recording Secretary.

GENERAL LUNCHEON SESSION

The Woman's Auxiliary to the State Medical Association of Texas reconvened at 1:00 p. m. Wednesday, May 8, 1946, in the Ballroom of the Buccaneer Hotel, Galveston, for a luncheon meeting.

The President, Mrs. Charles B. Alexander, San Antonio, called the meeting to order. Mrs. Paul Brindley, local hostess, announced a surprise, a style show staged by "The Medical Dames." The costumes were furnished by E. S. Levy. Mrs. Robert M. Moore's luncheon committee announced that the decorated shell nut cups were for the guests.

Mrs. W. Frank Armstrong, Fort Worth, gave the invocation, which follows:

INVOCATION

O God, who hast commanded that no man should be idle, give us grace to employ all our talents and faculties in the service appointed for us; that whatsoever our hand findeth to do, we may do it with our might. Cheerfully may we go in the road which Thou hast marked out, not desiring too earnestly that it should be either more smooth or more wide; but, daily seeking one way in Thy light, may we trust ourselves and the issue of our journey to Thee, the Fountain of joy, and sing songs of praise as we go along. Then, O Lord, receive us at the gate of life, which Thou hast opened for us in Christ Jesus. Amen.

The guests at the speakers table were introduced by the President, who also introduced the speaker, Dr. Titus H. Harris, as follows:

INTRODUCTION OF DR. TITUS H. HARRIS

It is with great pleasure that I present our speaker of the day. Dr. Titus H. Harris brings to us a subject in which we are vitally interested as individuals, as home makers, as doctors' wives, and most of all as Auxiliary members. Health education has always been the main project of the Auxiliary. Today health education has broadened to include mental health. We must have some knowledge of psychiatry if we are to continue to be leaders in the field of health education. Because every one today is talking about psychiatry, the public has become confused as to what is true and what is false. We are most fortunate today in having as our speaker Dr. Titus H. Harris, who is an authority upon this subject. Dr. Harris has gained note as a practicing psychiatrist, acquired distinction as a teacher in our State Medical School, won renown as a lecturer before national medical groups, and gained recognition as a writer in this his chosen field of psychiatry. It gives me great pleasure to present our honored guest, Dr. Titus H. Harris, of Galveston.

The address by Dr. Harris, entitled "The History of Psychiatry in Relation to Its Present Place in Medicine," is published in its entirety as an original article in this number of the JOURNAL (page 204).

Mrs. A. B. Pumphrey, Fort Worth, legislative chairman, reported on how the representatives and senators of the state stand on medicine, according to their voting records.

Mrs. Leslie Moore, Dallas, historian, gave the highlights of the Auxiliary's year, as follows:

REPORT OF HISTORIAN

Remembering that a history of any kind is often an uninteresting and tiresome part of a program and many times listened to with weariness, I shall keep in mind the watchword "brevity" and try to give only the highest of highlights.

The Woman's Auxiliary to the State Medical Association of Texas is meeting in a general session for the first time since the war began, having held only Executive Board meetings to transact necessary business during the war.

During the past year the world has passed from war to peace, and the Auxiliary along with the Medical Association is anxious to get back into its normal activities. Notwithstanding difficulties and heartaches this organization has carried on magnificently, meeting the wartime demands made upon it. Many of our members are women whose husbands and sons have been in military service at home and overseas, and others have participated in the war pressure which fell upon the physicians who had to shoulder double duties to make up for the shortage of doctors on the home front. By keeping the homes, the families, and in many cases the offices running smoothly, the doctors' wives have done much individually and as an organization have made a splendid contribution, particularly in legislation and public health education.

Our President, Mrs. Alexander, said when she accepted the gavel, "It is because our Auxiliary has always accepted every opportunity to be of service to our State Medical Association that we have grown and developed with the years." She has emphasized this statement through the year by her work. She sent form letters to all committee chairmen and county presidents outlining the program adopted at the Board meeting in May. She stressed the importance of being an informed membership at her Board meeting in September, and in keeping with this theme, she asked Dr. John Burleson, chairman of the Legislative Committee, and Dr. R. A. Miller, member of the Public Relations Committee of the State Medical Association, to speak. She has written hundreds of letters and traveled thousands of miles to attend National Board meetings and visit twenty auxiliaries in Texas. It has indeed been her busy year. Mrs. Alexander also said, "The Auxiliary needs every doctor's wife an active member, for every doctor's wife is a molder of public opinion through her social and club contacts."

The membership chairman, Mrs. S. M. Hill, Dallas, with the coöperation of her council women, reports the organization of four new county auxiliaries, making a total of fifty-eight with a paid membership of 2,241. Much stress has been put upon stimulating an interest in securing members-at-large, in this way giving the doctors' wives whose counties are too small to have an organization of their own an opportunity to become a part of the State Auxiliary. She reports 78 new members-at-large. "Every Doctor's Wife a Member" is our slogan.

This has indeed been a legislative year and with the splendid leadership of the legislative chairman, Mrs. A. B. Pumphrey, Fort Worth, the Auxiliary has done much to assist in promoting beneficial legislation and in combating that which is undesirable by speaking or writing to our Congressmen and by discussing the impending bills with other women's organizations whenever possible.

Under the direction of our chairman a poll tax campaign was launched in which seventeen county auxiliaries report having taken an active part. El Paso County Auxiliary with its 107 members headed the campaign with one of its members as chairman and established booths in drug stores, department stores, and other public buildings and broke all records in poll tax receipts. Along with this the auxiliary did much to educate the people on how to vote. Dallas County Auxiliary appointed a poll

tax campaign committee. These women contacted the heads of big organizations in the city urging them to stress the importance of paying their poll taxes and at this time distributed much literature on the evils of socialized medicine. Falls County Auxiliary members, with only seventeen, pledged themselves each to secure twenty-five persons to pay poll taxes and vote right. They also distributed 1,000 pamphlets on "Is Socialism Coming to Texas?"

Harris County Auxiliary members sent 130 communications to their Congressmen and report all had replies. Thirteen auxiliaries reported having had public relations meetings. Bexar County Auxiliary did an outstanding work by inviting all women's organizations of San Antonio to a public meeting to hear a woman lawyer talk on socialized medicine. El Paso also invited representatives from other clubs to hear talks on public health. Bowie-Miller and Washington Counties held public health meetings. Kerr-Kendall-Bandera-Gillespie did a splendid work in the sale of tuberculosis seals, having realized $1,515 from it. Auxiliary members donated $2.50 a month to the school cafeteria to furnish hot lunches to needy children. They gave patch tests to 400 students in rural and Negro schools in Kerr County along with many other services. Falls County carried out the Auxiliary's "Health Hints of the Month" in the Negro schools and gave a $5 prize for the best essay.

Grayson County again deserves special mention for its tremendous accomplishment in collecting blood for the Buchanan Blood Bank. The plasma program was launched in July, 1943, with an initial deposit of 294 units. Since that time the Auxiliary has sponsored five collections with a total of 3,712 pints of blood. Since the report last year the members have added 369 units.

Keeping the doctor and the doctor's family well has been stressed by almost all auxiliaries by urging annual physical examinations. Approximately 2,000 have been reported.

Angelina County, with sixteen members, reports fifty physical examinations. Potter County with twenty-five members reports seventy-five. Harris County with a membership of 351 reports 571 examinations, while Dallas with 371 members had 603. "Believe it or not," this is a tie; figure it out for yourself.

Liberty-Chambers, Nacogdoches, and Cherokee report 100 per cent JOURNAL readers with Taylor-Jones close up with an 85 per cent. Wichita and Cherokee entered essays for the state prize. Falls, Taylor-Jones, Galveston, and El Paso had local essays giving their own prizes.

An increased interest in *Hygeia* was reported. A total of 764 subscriptions were secured. Liberty-Chambers, Bowie-Miller, and Lamar had more *Hygeia* subscriptions than members.

Mrs. Cecil Patterson reported 40 *Bulletin* subscriptions. One of our newer auxiliaries, Cameron-Willacy, with eighteen members, reports 12 *Bulletin* subscriptions, 11 *Hygeia*, and 70 physical examinations.

The State Auxiliary has four philanthropic projects carried forward from year to year by contributions from the county auxiliaries. The Memorial Fund was founded in 1931 by our own late Mrs. John O. McReynolds as a memorial to her mother. This fund was established for the purpose of helping needy widows and families of doctors who were members of the State Medical Association at the time of their death. The chairman, Mrs. O. M. Marchman, Dallas, reports that this fund has increased until we now have ten $1,000 bonds and a surplus of around $257 to be used any time there is a need for it. She has received $869.67 this current year. Dallas County Auxiliary, Mrs. Marchman's own auxiliary, contributed $306 of this amount.

The George Plunkett Red Student Loan Fund, another worthy project, was established by our own late Mrs. Red, whose name it carries. This fund is also carried on by the county auxiliaries. The chairman, Mrs. William E. Ramsey, Houston, reports a total of $87 received from twelve auxiliaries. Harris County leads the list with a $25 donation.

Our Student Loan Fund, whose chairman, Mrs. M. L. Graves, always inspires us to greater things when she tells us of the letters of appreciation she has from the boys we have helped, reports nice donations. Galveston tops this list with $575.13. In the smaller groups Wichita, Washington, and Harrison deserve special mention. Harrison with a membership of nine gave $5. $1,816.76 was added this year.

Our newest project of State Auxiliary work is our Library Fund. About ten years ago the Library of the State Medical Association of Texas set up a package library service to physicians of Texas and three years ago the Woman's Auxiliary added this Library Fund to our other worthy causes. There is nothing the Auxiliary can do that will be more helpful in the advancement of scientific medicine in Texas than to sponsor and secure donations for this fund. Mrs. Frank Haggard, San Antonio, chairman, reports donations from county auxiliaries and memorial donations amounting to $225.25. Of this amount, Mrs. Haggard's own auxiliary, Bexar County, gave $100. Harris, Nueces, Hunt-Rockwall-Rains, Taylor-Jones, and Liberty-Chambers contributed to all four state funds. Aside from the contributions to these funds many auxiliaries reported gifts to local philanthropies. Harris and Dallas Counties both report several large donations.

Many assisted in bond sales, Red Cross drives, hospital drives, and many other local activities, all commendable. As historian I received clippings from an El Paso paper, and have read all county reports published in the JOURNAL. I have received twelve yearbooks. All have been sent to the Archives chairman.

It has been a real pleasure to study reports from forty-two county auxiliaries, making notes of the many achievements. It is possible to mention but a few of the highlights.

I am sure every county president could tell us of other activities that deserve honorable mention. If every doctor's wife in Texas could realize the wonderful opportunity for service in this organization the result would be beyond computation.

MRS. H. LESLIE MOORE, Dallas.

Mrs. Moore asked Mrs. S. M. Hill, Dallas to present awards to winning organizations. The following awards were announced.

MEMBERSHIP

Potter County Auxiliary won the silver loving cup with 48% increase in membership.

Tom Green	35%	Membership 1 to 25
Cherokee	22%	
Henderson	21%	
Potter	48%	Membership 25 to 50
Ector-Midland-Martin-Howard-Andrews-Glasscock	40%	
Smith	23%	
Travis	15%	Membership 50 to 100
McLennan	14%	
Jefferson	7%	
Dallas	15+%	Membership over 100
El Paso	14 %	
Galveston	9+%	

HYGEIA SUBSCRIPTIONS

First Group—Liberty-Chambers
Second Group—Bowie-Miller
Third Group—Lamar
Fourth Group—Dallas

BULLETIN SUBSCRIPTIONS

First Group—Cameron-Willacy
Second Group—Hardin-Tyler
Third Group—Nueces
Fourth Group—Dallas

PHYSICAL EXAMINATIONS

First Group—Angelina
Second Group—Potter
Third Group—Jefferson
Fourth Group—Harris

LEGISLATIVE

First Group—Cherokee
Second Group—Taylor-Jones
Third Group—El Paso
Fourth Group—Dallas

HEALTH TALKS AND FILMS

First Group—Falls
Second Group—Hunt-Rockwall-Rains
Third Group—Johnson
Fourth Group—El Paso

ESSAYS

First Group—Falls
Second Group—Wichita
Third Group—Cherokee
Fourth Group—Harris

PUBLIC RELATIONS

First Group—Washington
Second Group—Bowie-Miller
Third Group—Galveston
Fourth Group—Bexar

JOURNAL REPORTS

First Group—Henderson
Second Group—Travis
Third Group—Hunt-Rockwall-Rains
Fourth Group—Galveston

JOURNAL READERS

Cherokee—100 per cent
Liberty—100 per cent
Nacogdoches—100 per cent
Taylor-Jones—85 per cent

PHILANTHROPIC

Donated to all four funds:

Liberty-Chambers
Taylor-Jones
Nueces
Hunt-Rockwell-Rains

STUDENT LOAN

First Group—Smith
Second Group—Harrison
Third Group—Washington
Fourth Group—Galveston

GEORGE PLUNKETT RED FUND

Angelina
Taylor-Jones
Wichita
Harris

MEMORIAL

Harrison
Jefferson
McLennan
Dallas

LIBRARY

Ector-Midland-Martin-Howard-Andrews-Glasscock
Kerr-Kendall-Bandera-Gillespie
Wichita
Bexar

Mrs. W. S. Red, Jr., Houston, gave the following report from the Resolutions Committee:

REPORT OF RESOLUTIONS COMMITTEE

At this, the first postwar meeting of the Woman's Auxiliary to the State Medical Association, the Resolutions Committee asks that we pause a moment in silent thanksgiving with an earnest plea that the nations are working toward a world peace.

We are deeply grateful to the Woman's Auxiliary and the Galveston County Medical Society, its officers, committees, and individual members, for its gracious hospitality and untiring efforts to make our stay most pleasant; to the program committee for its delightful contributions; to the Galveston County Medical Society for its help; to the hotels, the local press, and the business organizations for their coöperation; and to the citizenry of Galveston for their generous hospitality.

We are also grateful to the officers of the State Medical Association for their guidance and suggestions, and to the editor and the staff of the State JOURNAL for their support.

This meeting has been stimulating and inspiring; we feel this is a time of rededication for both the doctors and their wives to the service of mankind.

The Registration Committee reported 440 registered.

The President called for the report of the Nominating Committee, which was presented by the chairman, Mrs. Sam Thompson, Kerrville, for the other members of the committee, Mesdames Frank Haggard, San Antonio; John T. Moore, Houston; C. M. Cash, San Benito; Cecil O. Patterson, Dallas; Ralph C. Cross, Texarkana; and W. Frank Armstrong, Fort Worth.

The President called for nominations for each office from the floor; there being no other nominations the vote was by acclamation according to the Constitution. The following officers were elected:

NEW OFFICERS

President—Mrs. George Turner, El Paso.

President-Elect—Mrs. C. F. Ferguson, Beaumont.

First Vice-President—Chairman of Organization—Mrs. L. B. Windham, Tyler.

Second Vice-President—Chairman of Physical Examinations—Mrs. V. M. Longmire, Temple.

Third Vice-President—Chairman of Hygeia—Mrs. R. E. Clark, Memphis.

Fourth Vice-President—Chairman of Program—Mrs. J. E. Hogan, Big Spring.

Corresponding Secretary—Mrs. Robert F. Thompson, El Paso.

Recording Secretary—Mrs. M. A. Ramsdell, San Antonio.

Publicity Secretary—Mrs. J. F. Campbell, Fort Worth.

Treasurer—Mrs. Guy Jones, Dallas.

Parliamentarian—Mrs. Joe Nichols, Atlanta.

Mrs. G. V. Brindley, Temple, installed the officers, using the following service:

INSTALLATION SERVICE

Since our husbands have as their primary interest in life the care and mending of the human body, our idea of perfection is the body that is sound and one that functions with ease and grace. So, I shall ask you to become the body which will carry forward this splendid organization of ours.

You, Madam President, shall be its head. Yours will be the task to plan, to dream, to execute so that all things will be well with us.

Madam President-Elect, you shall be the eyes to envision a future filled with promise and fulfilment.

Madam First Vice-President, Chairman of Organization, you shall be our arms to reach out and to hold us together and to bring into the fold those whom we need and those who sorely need us.

Madam Second Vice-President, Chairman of Physical Examinations, you shall be our sense of touch forever keeping a finger on the pulse to warn when danger lurks.

Madam Third Vice-President, Chairman of Hygeia, you shall be our breath, the source of inspiration and the fountain of true knowledge.

Madam Fourth Vice-President, Chairman of Program, you shall be our heart. For without a vitalizing, stimulating program the life of any organization ceases. No more important future exists.

Madam Corresponding Secretary, you are our circulatory system to carry fresh life to those who need our counsel and encouragement.

Madam Recording Secretary, you shall be memory, to keep an accurate record of our aims and achievements.

Madam Publicity Secretary, you shall be the voice to proclaim our success or our needs.

Madam Treasurer, you shall be the hands to hold and guard our treasures that they may increase to enable us to bestow them upon the worthy Me-

morial, Library, and Student Loan Funds and other worthwhile projects.

Madam Parliamentarian, you shall be the ears to listen to hear all hint of error that we may conform to rule and thus live in peace and harmony.

You, County and District Presidents, shall constitute all other vital parts to complete the perfect whole.

Last, but not least by any means, the Past Presidents shall be the soul, the spirit to hover over us and abide with us that our organization shall prosper to the end of time.

Mrs. Sam Thompson presented each officer with a beautiful handkerchief.

Mrs. R. F. Thompson, El Paso, presented Mrs. Turner with an arm bouquet of roses from her local auxiliary, and Mrs. Frank Haggard, San Antonio, presented Mrs. Alexander with an arm bouquet of roses from her local auxiliary.

Mrs. Alexander presented the gavel to Mrs. Turner with the following words:

Presentation of Gavel

Now that my term of President has expired and this year of joyous fellowship and service has ended, I pass this gavel of authority to my successor, Mrs. George Turner, a charming and capable lady. I bespeak for her the same abundance of love, courtesy, and loyalty you have given me.

I wish you, Mrs. Turner, and the new administration great joy and every success in this the twenty-ninth year of our Auxiliary.

Mrs. Turner accepted the gavel and gave her inaugural address, which follows:

Acceptance of Gavel and Inaugural Address

Mrs. Alexander, in accepting this gavel, the emblem of authority of the office, I do so with pride and a deep desire to be of the utmost service to the Woman's Auxiliary to the State Medical Association of Texas. I am fully aware of the honor and the responsibilities which accompany it and I do here and now pledge to you, who have so honored me, my loyal service and best efforts. Surely, with the help of this fine Executive Board, the support of our alert county auxiliaries, and the structure already so beautifully builded by our past regimes, we can add another successful year. I thank and congratulate you, and all of those who have gone before, on your achievements. Our growth is due to the service you have rendered. We have developed from a purely social organization to one of service to others; this has been done by educating ourselves and the public as to the aims, purposes, and accomplishments of our husbands' profession, which is the noblest on earth.

I have had the feeling for years that there is something about being President of this organization that leaves upon one some mark that more or less sets one apart. During the past year it has crystallized and seems now exactly as if a magic mantle has been placed around me to guide me right and steer me clear of mistakes. The interest, love, pride, and example of the past presidents of our Auxiliary which has come to me through letters and personal contact this past year have been my greatest source of inspiration.

And now a new year faces us. The wars are over. We can return to our original aims and purposes with renewed vigor. Our goal is: Every doctor's wife a member; every doctor's wife informed on our medical objectives; every doctor's wife a molder of public opinion on medical subjects through her outside contacts. Let us go all out with every effort to return to complete normalcy within the year.

We have certain well defined tasks to perform, namely, (1) promotion and sale of *Hygeia;* (2) yearly physical examinations for everyone; (3) public relations; (4) study of proposed medical legislation; (5) the sale of the *Bulletin* to all officers (and it would be a fine thing if it could be in the hands of all our members as well); (6) social activities designed to bring our members together in friendly relationship. These projects are in the hands of state and county chairmen who promote the work in various ways. As a result we have the health essay contest, health posters, health films, radio programs, health talks, physical examination clinics, public relations days, health institutes or forums, and "Doctor's Day," which is new but is becoming very popular nationally—its purpose is to honor our doctor husbands and it may be molded to fit any occasion which is designed for relaxation and entertainment.

Then we have certain work that pertains only in our own state, namely, (1) the Memorial Fund; (2) the Student Loan Fund; (3) the George Plunkett Red Scholarship Fund; (4) the Library Fund. Again, these projects are in the hands of well trained and enthusiastic chairmen. It is the duty and privilege of the county auxiliaries and individuals to support these funds so that our needy may be cared for, ambitious young men and women trained to take up their duties in caring for the sick. The Library Fund is particularly worthy because it is the source to which our doctors may turn in seeking information.

The Texas Auxiliary will gladly accept any suggestions for service handed down from the American Medical Association, the National Auxiliary, and the State Medical Association. It is our desire to do everything in our power to advance, perpetuate, defend, and protect our profession.

Thank you for asking me to be your President. Your confidence is inspiring and although no new thing may be asked of us, it is the high hope of this new year, that our work will be fruitful and satisfying in every way.

Mrs. Turner announced the Post Convention Board meeting would be held the following morning.

The meeting was declared adjourned, sine die, at 3:30 p. m.

Mrs. Wilber F. Robertson, San Antonio,
Recording Secretary.

MEMORIAL SERVICES

Impressive memorial services were held at 5:15 p. m. Wednesday, May 8, 1946, in the Ballroom of the Hotel Galvez, Galveston, in memory of Texas physicians and members of the Woman's Auxiliary who died during 1944 and 1945.

Dr. W. L. Crosthwait, Waco, chairman, Committee on Memorial Exercises, State Medical Association, presided. The invocation was given by Dr. W. R. Johnson, pastor of the First Presbyterian Church, Galveston.

Mrs. P. R. Denman, Houston, Memorial chairman, gave the Memorial Address for the Auxiliary as follows:

Memorial Address

"Beautiful life is that whose span
Is spent in duty to God and man;
Beautiful calm when the course is run;
Beautiful twilight at set of sun;
Beautiful death with a life well done."

During the past year, the Woman's Auxiliary to the State Medical Association has lost twelve members and we reverently pause at this hallowed hour to pay tribute to the memory of these who indeed made beautiful their lives in duty, and whose influence will live on as an inspiration to us. There is a spirit of fellowship, service, and love that rules in the hearts and lives of a group who are privileged to aid the truest of men, the doctor, and in our Auxiliary we have this opportunity, so the tie that binds is a bit closer than in the usual or-

ganization; therefore, the pain of loss is felt more keenly when "the silver cord be loosed, or the golden bowl be broken."

"It seemeth such a little way
Across to that strange country—the Beyond—
And yet not strange for it has grown to be
The home of those of whom we are so fond,
They make it seem familiar and most dear
As journeying friends bring distant regions near."

The following have journeyed into this "Beyond," the past year:

Mrs. J. M. Alexander, Abilene.
Mrs. S. W. Crossley, Del Rio.
Mrs. E. A. Duncan, El Paso.
Mrs. O. F. Gober, Temple.
Mrs. F. H. Jenkins, Waxahachie.
Mrs. Bruce A. Knickerbocker, Dallas.
Mrs. John S. Perry, Fredericksburg.
Mrs. W. R. Snow, Abilene.
Mrs. H. C. Thomas, Fort Worth.
Mrs. W. E. Vandevere, El Paso.
Mrs. Forrest A. White, Austin.
Mrs. Joe S. Wooten, Austin.

"The rose still grows beyond the wall—
Scattering fragrance far and wide,
Just as it did in the days of yore
Just as it did on the other side
Just as it will forever more."

Dr. Holman Taylor, Fort Worth, read the roll call of deceased members of the Medical Association, with Dr. Crosthwait giving the memorial address and paying tribute particularly to those who had died in service.

Vocal selections were given by Mr. Glenn Gordon, Galveston, accompanied by Mr. Victor H. Neal, Galveston.

Mrs. Wilber F. Robertson, San Antonio,
Recording Secretary.

POST-CONVENTION EXECUTIVE BOARD MEETING

On Thursday, May 9, 1946, at 9:30 a. m., thirty-five members of the Executive Board of the Woman's Auxiliary to the State Medical Association enjoyed a delightful breakfast in the home of Mrs. J. L. Jinkins, Galveston. Mrs. E. H. Marek, Yoakum, was cohostess.

Mrs. George Turner, El Paso, the new President, presided at the business meeting which followed. Her opening address follows:

Address of New President

May marks the beginning of a new Medical Auxiliary year. In the state and in each county auxiliary officers for the ensuing year are elected and installed. For many this will mean assuming these responsibilities for the first time. Let me urge all of you to study carefully your respective duties as set forth in our constitution—national, state, county. This is most essential. I have always been of the opinion that the next best thing to knowledge is where to find knowledge, for organization problems that arise are almost always answered by referring to the constitution and by-laws.

It is the duty of the newly elected president to call a meeting of her newly elected officers for instruction in the duties of their offices. This we have tried to do this year in our State School of Instruction here, which most of you have attended. I hope this school will continue each year and become perfected as time goes on. It is such an excellent time to study with and profit from those already experienced, and to get suggestions and ideas for new methods of approach for our problems and projects that county presidents might follow a similar plan when they get back home.

The work of one office depends largely on the work of the others and a general understanding of the duties of each office makes for efficiency and assures a year of successful work. Care should be given and personal responsibility felt in each office. State and county officers and committee members should possess the tools of their office. They are in general: National Handbook; State Constitution and By-laws; the National Bulletin; the State Journal; the A. M. A. *Journal*; and *Hygeia*. In some offices, like those of secretaries and treasurers, there is special equipment. I am going to ask you to equip yourself with these things and make use of them in your work.

Individually, we are triangular in nature—we all have a mental, physical, and spiritual side. Organizations are not unlike the individuals who make up their membership. The mental is our knowledge, coupled with the desire to fulfill our duties to the best of our ability. The physical is our projects which are the material outgrowth of our organization. The spiritual is that which blends the mental and physical into the coherent and effective whole which inspires our endeavors and achievements.

There are two very good words I want to call to your attention. I hope you will remember them throughout the year. They are worthy of your notebook and memory. One is *enthusiasm*. I think it is the first requisite of leadership. The other word is *understanding*. There is a little poem which expresses the spirit of understanding more beautifully than I can express it:

"If I knew the heart of you,
And you the soul of me,
We'd laugh and cry together always,
As friendly as could be.
You'd know the very minute
I said an unkind word,
And think, 'she's over tired'
And pretend you had not heard.
And if by chance you hurt me—well,
I never could complain,
For I would know you did not mean
To cause me hurt or pain.
And never would we lose our faith
Though near or far apart,
If I knew the soul of you,
And you could read my heart."
—Helen Loomis Linkham.

The invocation was given by Mrs. R. B. Homan, Sr., El Paso.

The President introduced the President-Elect, Mrs. E. C. Ferguson, Beaumont, who responded briefly.

Officers for the new year were announced and those present were introduced.

Chairmen and members of standing committees were announced as follows:

Standing Committees

Legislation.—Mrs. A. B. Pumphrey, Fort Worth.

Public Relations.—Mrs. Joe B. Foster, Houston.

Library.—Mrs. H. P. Ledford, Wichita Falls, chairman; Mrs. J. H. McCracken, Dallas; Mrs. J. R. Winston, Temple; Mrs. John A. Crockett, Austin.

Historian.—Mrs. E. H. Marek, Yoakum.

Student Loan Fund.—Mrs. M. L. Graves, Houston, chairman; Mrs. Willard Cooke, Galveston; Mrs. John T. Moore, Houston.

Exhibits.—Mrs. J. L. Jinkins, Galveston.

Archives.—Mrs. W. A. Wood, Waco, chairman; Mrs. Thomas Jarmon, Tyler; Mrs. W. Frank Armstrong, Fort Worth.

Research to Southern Medical Auxiliary.—Mrs. E. W. Coyle, San Antonio.

Bulletin.—Mrs. William Janssen, Corpus Christi.

Memorial Service.—Mrs. W. R. Thompson, Fort Worth, chairman; Mrs. John T. Moore, Houston; Mrs. O. R. Grogan, Fort Worth.

Budget and Finance.—Mrs. S. M. Hill, Dallas, chairman; Mrs. F. R. Rugeley, Wharton; Mrs. S. H. Watson, Waxahachie.

George Plunkett Red Fund.—Mrs. W. E. Ramsey, Houston, chairman.

Memorial Fund.—Mrs. O. M. Marchman, Dallas, chairman; Mrs. Joe B. Foster, Houston; Mrs. S. F. Harrington, Dallas.

Resolutions.—Mrs. Marvin Duckworth, Cuero, chairman; Mrs. J. C. Terrell, Stephenville.

Revisions.—Mrs. J. Frank Clark, Georgetown, chairman; Mrs. Ramsay Moore, Dallas; Mrs. Troy Shafer, Harlingen.

Reference.—Mrs. Mark H. Latimer, Houston, chairman; Mrs. William Hibbitts, Texarkana.

Nominating.—Mrs. Charles B. Alexander, San Antonio.

Advisory.—Mrs. Charles B. Alexander, San Antonio, chairman; Mrs. Sam Thompson, Kerrville; Mrs. A. B. Pumphrey, Fort Worth; Mrs. P. R. Denman, Houston; Mrs. S. F. Harrington, Dallas; Mrs. William Hibbitts, Texarkana; Mrs. Scott Applewhite, San Antonio.

Special Advisory.—Mrs. R. B. Homan, Sr., El Paso, chairman; Mrs. E. V. DePew, San Antonio; Mrs. F. F. Kirby, Waco; Mrs. John T. Moore, Houston; Mrs. Frank Haggard, San Antonio; Mrs. G. V. Brindley, Temple; Mrs. H. R. Dudgeon, Waco; Mrs. E. H. Cary, Dallas; Mrs. O. M. Marchman, Dallas; Mrs. H. C. Haden, Houston; Mrs. Joe Gilbert, Austin; Mrs. H. B. Trigg, Fort Worth; Mrs. S. M. Collom, Texarkana; Mrs. W. A. Wood, Waco; Mrs. M. L. Graves, Houston; Mrs. W. R. Thompson, Fort Worth; Mrs. S. H. Watson, Waxahachie.

Council women were announced as follows:

COUNCIL WOMEN

District 1.—Mrs. A. D. Long, El Paso.
District 2.—Mrs. A. J. Cooper, Midland.
District 3.—Mrs. W. R. Klingensmith, Amarillo.
District 4.—Mrs. D. W. Jordan, Brady.
District 5.—Mrs. H. H. Gallatin, Kerrville.
District 6.—Mrs. P. H. Frenzel, Donna.
District 7.—Mrs. T. J. McElhenney, Austin.
District 8.—Mrs. F. J. L. Blasingame, Wharton.
District 9.—Mrs. Jesse B. Johnson, Galveston.
District 10.—Mrs. John Carter, Beaumont.
District 11.—Mrs. George M. Hilliard, Jacksonville.
District 12.—Mrs. G. V. Brindley, Temple.
District 13.—Mrs. A. W. Brazda, Ranger.
District 14.—Mrs. O. W. Robinson, Paris.
District 15.—Mrs. Ralph C. Cross, Texarkana.

The county presidents present were introduced.

The President then introduced the hostesses: Mrs. J. L. Jinkins, Galveston, and Mrs. E. H. Marek, Yoakum.

The program chairman, Mrs. J. E. Hogan, Big Spring, presented plans for the year's work. She urged that the regular projects of the organization be continued, and recommended that the Auxiliary take an active part in the cancer drive; that the Hippocratic Oath and the meaning of Caduceus be studied. She also suggested that book reviews relating to medical subjects and biographies be given. She reemphasized the need for self-education of members along all lines pertaining to the medical profession, in order that the organization may be an influence for the education of the general public.

The Exhibits Committee chairman, Mrs. J. L. Jinkins, Galveston, requested instructions for policy setting from the Board. Upon the motion of Mrs. John T. Moore, Houston, seconded by Mrs. M. L. Graves, Houston, it was decided that the Board would take action on this matter at its next session. County presidents will be requested to have discussions of the topic in their groups and send the results of the discussions to the Board.

A motion by Mrs. J. E. Hogan, Big Spring, seconded by Mrs. A. B. Pumphrey, Fort Worth, that health essays be discontinued as a state project carried.

The President announced that the third member of the George Plunkett Red Scholarship Fund Committee is elected each year, and that nominatons were in order. Mrs. J. A. Watts, San Antonio, nominated by Mrs. W. A. Ramsay, Houston, was elected by acclamation.

Mrs. S. M. Hill, Dallas, presented the budget for the year:

BUDGET FOR 1946-1947

President's expense	$ 400.00
First vice-president	15.00
Fourth vice-president	10.00
Recording secretary	10.00
Treasurer	30.00
Auditor	35.00
Stationery	65.00
Membership list (typing)	5.00
A. M. A. Dues (Approx.)	594.00
	$1,164.00

The budget was adopted upon motion by Mrs. Hill, seconded by Mrs. E. H. Marek, Yoakum.

Mrs. A. B. Pumphrey, Fort Worth, moved, Mrs. P. R. Denman, Houston, seconded, that the President by reimbursed, as needed, for expenses incurred during her term of office. The motion carried.

The President was empowered to appoint delegates to the meeting of the Auxiliary to the American Medical Association to be held at San Francisco, July 1-4, 1946. From a list of volunteers the President will later announce the delegates appointed.

At the request of the President, the parliamentarian, Mrs. Joe D. Nichols, Atlanta, read from the Constitution that the Nominating Committee is elected by this body—three members of the Board and four members from the general body. The following were elected by acclamation: Mrs. Charles B. Alexander, San Antonio, chairman; Mrs. Scott C. Applewhite, San Antonio; Mrs. P. R. Denman, Houston; Mrs. H. S. Renshaw, Fort Worth; Mrs. Fred Sutton, Beaumont; Mrs. August Streit, Amarillo; Mrs. George Gallaher, Harlingen.

Mrs. A. B. Pumphrey, Fort Worth, cast the ballot.

The President invited the Board to come to El Paso for the next meeting, the exact date to be announced later. Mrs. Paul Brindley, Galveston, moved, Mrs. William Janssen, Corpus Christi, seconded, that the Board meet in El Paso. The motion carried.

It was moved by Mrs. Scott C. Applewhite, San Antonio, seconded by Mrs. A. D. Long, El Paso, that the corresponding secretary send a telegram of sympathy to Mrs. L. B. Windham, Tyler, whose brother had passed away. The motion carried.

An amendment by Mrs. E. H. Marek, Yoakum, that a telegram of sympathy also be sent to Dr. Titus H. Harris, Galveston, whose mother had died, also carried.

The Board regretted that, because of the pressure of duties as a member of the House of Delegates, Dr. C. C. Cody, Houston, President-Elect of the State Medical Association, was unable to deliver his address, "Prospectus for 1946-1947."

The President then expressed her personal appreciation, as well as the thanks of the Board, to the hostesses for their hospitality.

There being no further business, the meeting adjourned sine die.

MRS. M. A. RAMSDELL, San Antonio,
Recording Secretary.

MEMBERSHIP

Woman's Auxiliary to the State Medical Association of Texas

MAY, 1946

The membership list which follows is compiled from names sent to the State Treasurer, by county auxiliaries, as this year's paid-up members.

The Councilor Districts of the Auxiliary are the same as those of the State Medical Association, which are as follows:

No. 1. El Paso District, embracing the following counties: Brewster, Culbertson, El Paso, Hudspeth, Jeff Davis, Loving, Pecos, Presidio, Reeves, Ward and Winkler.

No. 2. Big Spring District, embracing the following counties: Andrews, Borden, Dawson, Dickens, Ector, Fisher, Gaines, Garza, Glasscock, Howard, Kent, King, Lynn, Martin, Midland, Mitchell, Nolan, Scurry, Stonewall, Terry and Yoakum.

No. 3. Panhandle District, embracing the following counties: Armstrong, Bailey, Briscoe, Carson, Castro, Childress, Cochran, Cottle, Collingsworth, Crosby, Dallam, Deaf Smith, Donley, Floyd, Foard, Gray, Hale, Hall, Hansford, Hardeman, Hartley, Hemphill, Hockley, Hutchinson, Lamb, Lipscomb, Lubbock, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher and Wheeler.

No. 4. San Angelo District, embracing the following counties: Brown, Coke, Coleman, Comanche, Concho, Crane, Crockett, Irion, Kimble, Mason, Menard, Mills, McCulloch, Reagan, Runnels, San Saba, Schleicher, Sterling, Sutton, Tom Green and Upton.

No. 5. San Antonio District, embracing the following counties: Atascosa, Bandera, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Gonzales, Guadalupe, Karnes, Kendall, Kerr, Kinney, LaSalle, Maverick, Medina, Real, Terrell, Uvalde, Val Verde, Wilson and Zavala.

No. 6. Corpus Christi District, embracing the following counties: Aransas, Bee, Brooks, Cameron, Duval, Hidalgo, Jim Hogg, Jim Wells, Kenedy, Kleberg, Live Oak, McMullen, Nueces, Refugio, San Patricio, Starr, Webb, Willacy and Zapata.

No, 7, Austin District, embracing the following counties: Bastrop, Blanco, Burnet, Caldwell, Hays, Lampasas, Lee, Llano, Travis and Williamson.

No. 8. DeWitt District, embracing the following counties: Calhoun, Colorado, DeWitt, Fayette, Fort Bend, Goliad, Jackson, Lavaca, Matagorda, Victoria and Wharton.

No. 9. Southern District, embracing the following counties: Austin, Brazoria, Burleson, Galveston, Grimes, Harris, Madison, Montgomery, Polk, San Jacinto, Trinity, Waller, Walker and Washington.

No. 10. Southeastern District embracing the following counties: Angelina, Chambers, Hardin, Japer, Jefferson, Liberty, Nacogdoches, Newton, Orange, Panola, Rusk, Sabine, San Augustine, Shelby and Tyler.

No. 11. Eastern District, embracing the following counties: Anderson, Cherokee, Freestone, Henderson, Houston, Leon and Smith.

No. 12. Central District, embracing the following counties: Bell, Bosque, Brazos, Coryell, Erath, Falls, Hamilton, Hill, Hood, Johnson, Limestone, McLennan, Milam, Navarro, Robertson and Somervell.

No. 13. Northwestern District, embracing the following counties: Archer, Baylor, Callahan, Clay, Eastland, Haskell, Jack, Jones, Knox, Montague, Palo Pinto, Parker, Shackelford, Stephens, Tarrant, Taylor, Throckmorton, Wichita, Wilbarger, Wise and Young.

No. 14. Northern District, embracing the following counties: Collin, Cooke, Dallas, Delta, Denton, Ellis, Fannin, Franklin, Grayson, Hopkins, Hunt, Kaufman, Lamar, Rains, Rockwall, Van Zandt and Wood.

No, 15. Northeastern District, embracing the following counties: Bowie, Camp, Cass, Gregg, Harrison, Marion, Morris, Red River, Titus and Upshur.

FIRST OR EL PASO DISTRICT

Mrs. A. D. Long
El Paso
Council Woman

EL PASO COUNTY AUXILIARY*

Awe, Mrs. Chester D., First National Bank Bldg.
Barrett, Mrs. F. O., 2733 Gold St.
Bennett, Mrs. J. T., 2611 Altura Blvd.
Black, Mrs. A. P., 2735 Federal St.
Breck, Mrs. L. W., 2720 Copper St.
Britton, Mrs. Bloyce, 1108 W. 8th St., Santa Ana, Calif.
Britton, Mrs. W. W., 1216 N. Mesa Ave.
Brown, Mrs. C. P., 2900 Federal St.
Brunner, Mrs. George, 908 Winter.
Butler, Mrs. A. H., 3207 Memphis.
Cameron, Mrs. David, 4700 Hastings.
Carter, Mrs. J. C., 1512 Elm.
Causey, Mrs. E. G., 1009 Park Rd.
Cummins, Mrs. E. J., 4011 Pershing Dr.
Curtis, Mrs. W. R., 1501 Rim Rd.
Davis, Mrs. W. J., Anthony, N. M.
Deady, Mrs. H. P., Montoya Lane.
Dietrich, Mrs. H. W., 3004 Savannah.
Dunne, Mrs. G. M., Sierra Blanca.
Dutton, Mrs. L. O., Emory Way.
Eck, Mrs. Andrew J., North Loop Rd.
Edwards, Mrs. George, 1301 Montana.
Egbert, Mrs. Orville, 3000 Federal.
Epstein, Mrs. I. M., 4001 Cumberland.
Evans, Mrs. F. G., 3508 Jackson.
Feener, Mrs. L. C., 911 E. Kerbey.
Fuchlow, Mrs. J. Richard, 4301 Hastings.
Gaddy, Mrs. S. J., 912 N. Mesa.
Gallagher, Mrs. Paul, 1445 E. California.
Goodloe, Mrs. B. L., 3200 Memphis.
Goodwin, Mrs. F. C., 925 Rim Rd.
Gorman, Mrs. J. J., 3100 Federal.
Green, Mrs. J. L., 3012 Silver.
Hardy, Mrs. John A., 800 Prospect.
Hart, Mrs. M. S., 3127 Wheeling St.
Hatfield, Mrs. H. D., 2330 Montana.
Hendricks, Mrs. C. M., 3601 McKinley.
Hinton, Mrs. J. H., 3611 Douglas.
Holt, Mrs. Russell, 2735 Wheeling.
Homan, Mrs. R. B., Jr., 3117 Copper.
Homan, Mrs. R. B., Sr., 1837 Grandview.
Homan, Mrs. R. H., First National Bank Bldg.
Hughes, Mrs. R. P., La Union, N. M.
Irvin, Mrs. E. H., 321 W. Rio Grande.
Jamieson, Mrs. W. R., 1205 Robinson.
Jones, Mrs. E. P., 1217 N. Mesa Ave.
Jordan, Mrs. G. H., 4515 Cumberland.
Jumper, Mrs. C. E., 1511 N. Virginia.
Keller, Mrs. N. H., 700 Cincinnati.
King, Mrs. Jack A., 1224 Galloway.
King, Mrs. Sam, 3301 Hueco.
Kitterman, Mrs. P. G., 4627 Alameda Ave.
Laws, Mrs. J. W., 701 N. St. Vrain.
Leigh, Mrs. Harry, 2619 Altura.
Liddell, Mrs. T. C., 2731 Richmond.
Long, Mrs. A. D., 1805 Elm.
McCamant, Mrs. T. J., 4500 Trowbridge.
McChesney, Mrs. Paul E., 401 Robinson Blvd.
McClain, Mrs. J. N., Fabens.
McNeil, Mrs. Irving, 1917 N. Mesa.
Marshall, Mrs. A. G., 3919 Chester.
Martin, Mrs. J. D., 3003 Louisville.
Mason, Mrs. C. H., 4430 Oxford.
Miller, Mrs. F. P., 5 Cumberland Circle.
Molloy, Mrs. M. S., 502 Cincinnati.
Morrison, Mrs. J. E., 800 College.
Multhauf, Mrs. A. W., 1101 Baltimore.
Pangman, Mrs. W. J., 1216 Winter.
Peticolas, Mrs. J. D., 3705 Chester.
Reed, Mrs. P. H., 3019 Altura.
Rennick, Mrs. Charles, 411 Blacker.
Rennick, Mrs. Samuel, Hotel Cortez.
Rheinheimer, Mrs. E. W., 3124 Aurora.
Rigney, Mrs. Paul W., 2718 Wheeling.
Rogde, Mrs. Jacob, Clark Rd., Box 98.
Rogers, Mrs. E. B., 1601 E. Rio Grande.
Rogers, Mrs. H. Earl, 2518 Richmond.
Rogers, Mrs. S. Perry, 1140 Galloway.
Rogers, Mrs. Will P., 901 Montana.
Schuster, Mrs. F. P., 939 Rim Rd.
Schuster, Mrs. S. A., 1000 N. Mesa.
Scott, Mrs. T. E., 1133 Baltimore.
Shanley, Mrs. T. J. B., 25 Cumberland Circle.
Shannon, Mrs. Hugh, 1307 Cincinnati.
Smith, Mrs. Leslie, 2827 Lebanon.
Snidow, Mrs. F. A., 3429 Lebanon.
Spearman, Mrs. M. P., 1124 Baltimore.
Spier, Mrs. Erich, 918 McKelligon.
Stapp, Mrs. C. C., Emory Way.
Stevens, Mrs. B. F., 217 Blacker.
Stevenson, Mrs. W. H., 503 Cliff.
Stowe, Mrs. Jesson L., 1104 Cincinnati.
Swope, Mrs. S. D., 1127 Montana.
Terrell, Mrs. S. L., 2600 Richmond.
Thompson, Mrs. R. F., 1227 Rim Rd.
Treece, Mrs. A. A., Fabens.
Turner, Mrs. George, 3009 Silver St.
Vance, Mrs. James, 1717 N. Mesa.
Vandevere, Mrs. W. E., 1919 N. Stanton.
Varner, Mrs. H. H., 3030 Wheeling.
Villareal, Mrs. L., Caples Bldg.
Von Almen, Mrs. S. G., 605 Robinson.
Von Briesen, Mrs. Delphin, 2800 Copper St.
Walker, Mrs. N. F., First National Bank Bldg.
Webb, Mrs. C. E., 1211 N. Mesa.
Weiss, Mrs. E. J., 1827 N. Mesa.
Wilcox, Mrs. L. E., 4779 Cumberland.

*Address is El Paso unless otherwise stated.

SECOND OR BIG SPRING DISTRICT

Mrs. A. J. Cooper
Midland
Council Woman

ECTOR-MIDLAND-MARTIN-HOWARD-ANDREWS-GLASSCOCK COUNTIES AUXILIARY*

Absher, Mrs. L. A., Midland.
Barganier, Mrs. J. H., Odessa.
Bennett, Mrs. M. H.
Bobo, Mrs. Tom C., Midland.
Briggs, Mrs. H. A., Midland.
Britt, Mrs. C. S., Midland.
Chapple, Mrs. James H., Midland.
Cooper, Mrs. A. J., Midland.
Cowper, Mrs. R. B. G.
Devereux, Mrs. J. M., Midland.
Dickerson, Mrs. M. D., Midland
Friedewald, Mrs. V. E.
Fulcher, Mrs. O. A., Odessa.
Golladay, Mrs. R. M., Midland.
Hall, Mrs G. T.
Headlee, Mrs. E. V., Odessa.
Hogan, Mrs. J. H.
Howser, Mrs. John P.
Johnson, Mrs. Homer B., Midland.
Leggett, Mrs. L. Waldo, Midland.
Lekisch, Mrs. Kurt, Midland.
Lester, Mrs. R. T.
McIntire, Mrs. L. R.
Malone, Mrs. P. W.
Miller, Mrs. Garnett.
Orr, Mrs. Charles W., Odessa.
Patton, Mrs. D. L., Midland.
Sanders, Mrs. Preston R.
Strauss, Mrs. E. H.

*Address is Big Spring unless otherwise stated.

Thomas, Mrs. Clyde E.
Whitehouse, Mrs. W. G., Midland.
Williamson, Mrs. T. J.
Wilson, Mrs. C. E.
Wood, Mrs. G. H.
Woodall, Mrs. J. M.

MEMBERS-AT-LARGE, SECOND DISTRICT

Young, Mrs. T. D., Roscoe.
Young, Mrs. T. D., Jr.

THIRD OR PANHANDLE DISTRICT

Mrs. W. R. Klingensmith
Amarillo
Council Woman

CHILDRESS-COLLINGSWORTH-HALL COUNTIES AUXILIARY

Clark, Mrs. R. E., Memphis.
Goodall, Mrs. O. R., Memphis.
Jernigan, Mrs. J. H., Childress.
Jeter, Mrs. P. R., Childress.
Jones, Mrs. C. B. Wellington.
Jones, Mrs. E. W., Wellington.
Odom, Mrs. J. A., Memphis.
Townsend, Mrs. S. H., Childress.
Wilson, Mrs. W., Memphis.
Post, Mrs. G. W., Clarendon.

LUBBOCK-CROSBY COUNTIES AUXILIARY*

Arnett, Mrs. Samuel C., Jr., 2211 14th.
Barsh, Mrs. Albert G., 2511 22nd.
Batson, Mrs. C. B., 2203 22nd.
Benson, Mrs. Martin H., 1625 Ave. Y.
Blake, Mrs. Emerson M., 3311 20th.
Canon, Mrs. R. T., 2613 19th.
Clark, Mrs. Doyce M., 3017 19th.
Clark, Mrs. Vester V., 2617 19th.
Cross, Mrs. Denzil D., 3001 20th.
Dunn, Mrs. Samuel G., Levelland Rd.
English, Mrs. Otis W., 2808 19th.
Ewing, Mrs. Mahon M., 2504 23rd.
Fiel, Mrs. Charles A., Jr., 3801 19th.
Hand, Mrs. O. Robert, 3021 22nd.
Harris, Mrs. Joseph R., Jr., 2316 32nd.
Hunt, Mrs. Ewell L., 2423 22nd.
Hutchinson, Mrs. Ben B., 2815 23rd.
Hutchinson, Mrs. J. T., 1519 Broadway.
Jenkins, Mrs. B. Arthur, 2124 30th.
Key, Mrs. Olan, 2303 18th.
Krueger, Mrs. Julius T., 2703 19th.
Lattimore, Mrs. J. P., Tahoka Highway.
Loveless, Mrs. Roy G., 2434 22nd.
McCarty, Mrs. Robert H., 1915 28th.
Malone, Mrs. Frank B., 2435 21st.
Mansell, Mrs. C. C., 1312 Main.
Mast, Mrs. Henri, 1919 28th.
Maxwell, Mrs. Herbert C., 2417 Broadway.
Overton, Mrs. Marvin C., 2523 21st.
Rollo, Mrs. James W., 1302 Ave. S.
Rountree, Mrs. J. B., Jr., 2401 30th.
Smith, Mrs. Gerald S., 2012 24th.
Standefer, Mrs. Fred W., 3105 21st.
Stewart, Mrs. Allen T., 3120 21st.
Stiles, Mrs. James H., 3002 22nd.
Wagner, Mrs. C. J., 1644 Broadway.

POTTER COUNTY AUXILIARY†

Black, Mrs. R. P., 2409 Hughes St.
Carrol, Mrs. Ralph, 2223 Hughes St.
Churchill, Mrs. T. P., 2116 Ong St.
Duncan, Mrs. Frank B., 2047 Hughes St.
Flamm, Mrs. Kenneth, 801 LaSalle St.
Gist, Mrs. R. D., 2615 Hayden St.
Hendrick, Mrs. J. W., 3009 Hughes St.
Johnson, Mrs. J. B., 823 Travis St.
Klingensmith, Mrs. W. R., 2415 Lipscomb St.
Lemmon, Mrs. J. R., 1028 Bowie St.
Marsalis, Mrs. Don S., 1502 Bowie St.
Owens, Mrs. Guy., 1009 Sunset St.
Puckett, Mrs. B. M., 2122 Monroe St.
Puckett, Mrs. Howard E., 2412 Lipscomb St.
Robberson, Mrs. Jason H., 1001 Avondale St.
Rowley, Mrs. E. A., 1004 Crockett St.
Royce, Mrs. George T., 2024 Ong St.
Streit, Mrs. A. J., 2413 Hayden St.
Swindell, Mrs. R. R., 2218 Hayden St.
Vaughn, Mrs. J. H., 1607 Van Buren St.
Vineyard, Mrs. R. L., 1801 Harrison St.
Wertz, Mrs. Royal F., 1315 Broadmore St.
White, Mrs. J. B., 2035 Ong St.

*Address is Lubbock unless otherwise stated.
†Address is Amarillo unless otherwise stated.

Winsett, Mrs. A. E., 2208 Hughes St.
Waddill, Mrs. G. Marion, 1206 Western Ave.

FOURTH OR SAN ANGELO DISTRICT

Mrs. D. W. Jordan
Brady
Council Woman

BROWN-COMANCHE-MILLS-SAN SABA COUNTIES AUXILIARY

Allen, Mrs. H. B., 1710 Vincent, Brownwood.
Bullard, Mrs. C. C., 1616 Austin, Brownwood.
Cadenhead, Mrs. E. F., 2401 Coggin Ave., Brownwood.
Campbell, Mrs. J. M., Goldthwaite.
Hughes, Mrs. S. W., Coleman.
Lobstein, Mrs. H. D., 1007 Coggin Ave., Brownwood.
McFarlane, Mrs. Joe R., 1312 Cottage, Brownwood.
Wheelis, Mrs. P. M., 115 Bluffview, Brownwood.

TOM GREEN-EIGHT COUNTY AUXILIARY*

Carbrey, Mrs. T. F., Hotel Cactus.
Finks, Mrs. R. M., 1510 Paseo De Vaca.
French, Mrs. C. M.
Hixon, Mrs. W. C., 429 W. Ave. C.
Horney, Mrs. Harlan, 420 W. Ave. C.
Hutchins, Mrs. L. F., 2202 Dallas.
Lewis, Mrs. A. L., 119 E. Beauregard.
McAnnulty, Mrs. J. P., 1005 S. Park.
Mitchell, Mrs. W. G., 121 N. Washington.
Rape, Mrs. J. M., 1521 W. Harris.
Schulze, Mrs. V. E., Christoval Rd.
Smith, Mrs. J. H., 1300 Paseo De Vaca.
Womack, Mrs. C. T., 222 N. Madison.

FIFTH OR SAN ANTONIO DISTRICT

Mrs. H. H. Gallatin
Kerrville
Council Woman

†BEXAR COUNTY AUXILIARY

Adams, Mrs. S., 404 Bushnell Apts.
Aderhold, Mrs. J., 221 Claremont.
Alexander, Mrs. C. B., 2003 W. Magnolia.
Allen, Mrs. S. W., Plaza Hotel.
Allin, Mrs. F., 1539 Hicks.
Allin, Mrs. Willis, 402 Garrity.
Altgelt, Mrs. D. D., 2127 W. Magnolia.
Alvis, Mrs. Milton E., 1426 W. Lynwood.
Anderson, Mrs. J. L., 166 Elizabeth Rd.
Applewhite, Mrs. S. C., 401 E. Park Ave.
Arendt, Mrs. E. J., 625 Shook Ave.
Atkinson, Mrs. D. T., Huebner Rd.
Atmar, Mrs. R. C., 206 Canterbury.
Barbato, Mrs. L.
Barnett, Mrs. J. L., 223 Laurel Heights Pl.
Bates, Mrs. L. E., 215 Ewald.
Beach, Mrs. Asa, 129 E. Summit.
Beck, Mrs. L. K., 1420 McCullough.
Bell, Mrs. J. D. (Assoc.), 148 Thoraine.
Berchelman, Mrs. A., 901 W. Mistletoe.
Biggar, Mrs. J. H., 242 Rockwood.
Blair, Mrs. W. F., 2003 W. Huisache.
Bloom, Mrs. B., 128 Furr.
Bocellato, Mrs. S. L., 923 W. Huisache.
Boehs, Mrs. C. J., 135 W. Hollywood.
Bondurant, Mrs. W. W., 430 College Blvd.
Bosshardt, Mrs. C. (Assoc.), 227 Claudia.
Bosshardt, Mrs. C. E., 210 E. Lullwood.
Bowen, Mrs. P. G., 331 W. Kings Highway.
Bowen, Mrs. R. E., 1849 W. Gramercy Pl.
Bowen, Mrs. R. E., Jr., 2245 W. Magnolia.
Boyd, Mrs. G. D., 310 E. Craig.
Breuer, Mrs. Alfred, 433 Canterbury Hill.
Brown, Mrs. A. A., 719 Howard.
Brown, Mrs. L. R., Box 1840.
Burg, Mrs. E., 2167 W. Summit.
Burk, Mrs. W. E., 310 Donaldson.
Bush, Mrs. H. M., 1540 W. Huisache.
Butler, Mrs. T. B., 244 Belvidere.
Cade, Mrs. C. H., 307 E. Park.
Cade, Mrs. W. H., 111 Canterbury.
Calder, Mrs. R. M., 108 Geneseo Rd.
Calvert, Mrs. H., 1330 Hicks.
Cassity, Mrs. J. C., 325 Cloverleaf.
Cayo, Mrs. E. A., 303 Broadview Dr. W.
Celaya, Mrs. H., 631 Ciruela.
Champion, Mrs. A. N., 135 W. Rosewood.

*Address is San Angelo unless otherwise stated.
†Address is San Antonio unless otherwise stated.

Childers, Mrs. M. A., Jr., Nacogdoches Rd.
Christian, Mrs. T. E., 450 Mary Louise Dr.
Clark, Mrs. A. F. 316 E. Craig.
Clark, Mrs. A. F., Jr., 704 Elmwood.
Cooper, Mrs. E., 119 E. Wildwood Dr.
Cooper, Mrs. F. B., 801 Elmwood.
Cooper, Mrs. M. J., 206 Primera Dr.
Copeland, Mrs. J. B., 322 W. Kings Highway.
Cowles, Mrs. A. G., 202 W. Kings Highway.
Coyle, Mrs. E. W., 213 Grant.
Coyle, Mrs. J. E., 213 Grant.
Crain, Mrs. C. E., 417-A Eleanor.
Crockett, Mrs. R. H., 214 Albany.
Cunningham, Mrs. S. P. (Assoc.), 116 W. Woodlawn.
Cutter, Mrs. I. T., 232 W. Lullwood.
Davis, Mrs. Milton, 945 S. Huisache.
Davis, Mrs. Raleigh, 636 E. Olmos Dr.
Davis, Mrs. Robert, 219 Southcross.
DeLeon, Mrs. J. J., 511 Club Dr.
DePew, Mrs. E. V., 115 E. Agarita.
Dittman, Mrs. C. H., 615 Ciruella.
Dorbandt, Mrs. M., 104 E. Norwood.
Dreiss, Mrs. A. M., 319 Mission.
Dufner, Mrs. Romie, 107 Eads.
Dumas, Mrs. E. D., 418 W. French Pl.
Engelke, Mrs. A. (Assoc.), 205 Terrell Rd
Fargo, Mrs. W. C. (Assoc.), 146 Harrigan.
Fetzer, Mrs. W. J., 220 W. Elsmere.
Fisher, Mrs. R. E., 510 King's Court.
Folbre, Mrs. T. W., 335 Garrity Rd.
Forbes, Mrs. M. A., 200 Warwick.
Franke, Mrs. W. I., 106 E. Gramercy Pl.
Freeman, Mrs. F. M., Jr. (Assoc.)
French, Mrs. J. A., 402 W. Gramercy Pl.
French, Mrs. S. W., 218 Encino.
Geyer, Mrs. G. H., 747 E. Ashby.
Giesecke, Mrs. A. (Assoc.), 203 W. Myrtle.
Giesecke, Mrs. C., 105 W. Rosewood.
Gilbreath, Mrs. S. F., 115 Thelma Dr.
Giles, Mrs. C., 2227 W. Mistletoe.
Glober, Mrs. R. A., 130 W. Kings Highway.
Goeth, Mrs. C. F., 125 E. Huisache.
Goeth, Mrs. R. A., 125 E. Huisache.
Goode, Mrs. J. W., 134 Hermosa Dr.
Goodpasture, Mrs. J. E., 805 W. Summit.
Goodson, Mrs. T. N., Gunter Hotel.
Goodwin, Mrs. R. T., 124 Barilla.
Gossett, Mrs. R. F., 625 Lamont.
Graves, Mrs. Amos, 222 Geneseo Rd.
Graves, Mrs. W. E., 804 W. Poplar.
Haggard, Mrs. C. H., 624 Lamont.
Haggard, Mrs. F. N. (Hon.), 615 E. Olmos Dr.
Haile, Mrs. J. T. (Assoc.), New Braunfels.
Hairston, Mrs. J. T., 426 Donaldson.
Hamilton, Mrs. W. S. (Assoc.), 207 Grand View.
Hargis, Mrs. H., 231 Inslee.
Hartman, Mrs. A. W., Jr., 138 E. Elsmere.
Hartman, Mrs. H., 831 W. Lynwood.
Heck, Mrs. W. H., 421 Mary Louise Dr.
Heinen, Mrs. A. (Assoc.), Seguin.
Helfer, Mrs. L. M., 236 Tuxedo.
Herff, Mrs. A. F., 363 Terrell Rd.
Herff, Mrs. F. P., 615 W. Ashby.
Hill, Mrs. H., 311 W. Lullwood.
Hill, Mrs. L., 131 Brittany Dr.
Holshouser, Mrs. C. A., 226 W. Gramercy Pl.
Hoskins, Mrs. H. R., 301 Pershing Ave.
Hunt, Mrs. K. N., 525 E. Mayfield Blvd.
Jackson, Mrs. L. B., 203 W. Mulberry.
Jackson, Mrs. L. W., 1530 W. Gramercy Pl.
Jackson, Mrs. R. S., 201 Mary Louise Dr.
Jensen, Mrs. A. M., 851 Avant.
Jensen, Mrs. M. H., 330 Furr Dr.
Johnson, Mrs. Harry McC., 130 W. Norwood.
Johnson, Mrs. Max E., 125 E. Kings Highway.
Johnson, Mrs. Ted, 811 Erie.
Johnson, Mrs. W. J., 423 Donaldson.
Judkins, Mrs. O. H., 240 W. Summit.
Kahn, Mrs. I. S., 128 Harrison Ave.
Kaliski, Mrs. B. (Assoc.), 339 E. Craig.
Kaliski, Mrs. Sidney, 1436 McKinley.
Keating, Mrs. P. M., 222 King William St.
Kelley, Mrs. Cole, 402 Harrison Ave.
Kenney, Mrs. Nat M., 222 E. Poplar.
King, Mrs. A. C., 912 W. Agarita.
King, Mrs. W. A., Pandora.
Klieforth, Mrs. F. H., 316 Cloverleaf.
Kopecky, Mrs. Joe, 627 Lamont.
Kopecky, Mrs. Leon, 526 College.
Kupper, Mrs. R. C., 422 Harrison Ave.
Ladd, Mrs. G. B., 719 Fulton Court.
Leap, Mrs. H. L., 241 King William St.
Landers, Mrs. R. W., Hondo.
Lee, Mrs. L. L., 270 Oakview.
Lehmann, Mrs. C. Ferd, 336 Terrell Rd.

Leopold, Mrs. H. N., 708 Wiltshire.
Letteer, Mrs. C. R. (Assoc.), San Pedro.
Letteer, Mrs. Ralph, 504 King William St.
Livingston, Mrs. Charles S., 315 Princeton.
Lochte, Mrs. E. R., Vance Jackson Rd.
Luedemann, Mrs. Waldo S., 503 Donaldson.
Lyon, Mrs. E. F., 2115 W. Gramercy Pl.
McCamish, Mrs. E. W., 120 Magnolia.
McComb, Mrs. Asher, 106 N. Loop Rd.
McCurdy, Mrs. M. W., 601 Mandalay Dr.
McGehee, Mrs. Charles, 236 Quentin Dr.
McGehee, Mrs. J. S. (Assoc.), 130 W. Norwood.
McIntosh, Mrs. J. A., 208 W. Woodlawn.
Magrish, Mrs. Phillip, 109 Ridgewood.
Manhoff, Miss S. (Assoc.), 818 W. Woodlawn.
Martin, Mrs. O. O. (Assoc.), 1136 Hammond.
Mason, Mrs. Otis (Assoc.), 254 Castano.
Matthews, Mrs. J. L., 114 E. Gramercy Pl.
Maxwell, Mrs. E. A., 119 W. Rosewood.
Maxwell, Mrs. W. W., 932 W. Woodlawn.
Mayes, Mrs. L. P., 607 Mandalay Dr. E.
Merrick, Mrs. Ed H., 2150 W. Magnolia.
Milburn, Mrs. Conn L., 331 W. Magnolia.
Milburn, Mrs. K. A., 347 Charles Rd.
Mileau, Mrs. Alexander, 514 Pershing Ave.
Miller, Mrs. J. B., 1811 E. Commerce
Miller, Mrs. J. B., Jr., 117 Brittany Dr.
Minsch, Mrs. Walter A., 275 Halcyon.
Minter, Mrs. Merton M., 150 Oakmont.
Moore, Mrs. John M., 227 Park Hill Dr.
Moore, Mrs. O. S., 1846 W. Magnolia.
Moore, Mrs. S. Foster, 327 Wildrose.
Moore, Mrs. T. E. (Assoc.), 110 E. Craig.
Mueller, Mrs. Edwin, 154 Barilla.
Muldoon, Mrs. W. E., 308 Park Dr.
Nesbit, Mrs. W. E., 221 W. Mistletoe.
Newhouse, Mrs. O. A. (Assoc.), 325 Magnolia.
Nicholson, Mrs. J. R., 5609 New Braunfels.
Nisbet, Mrs. Alfred A.
Nixon, Mrs. J. W., 129 E. Gramercy Pl.
Nixon, Mrs. P. I., 20 E. Courtland.
Nixon, Mrs. P. I., Jr., 202 E. Courtland.
Nunn, Mrs. J. A., 227 Cunningham.
Ogilvie, Mrs. H. H., 137 E. Elsmere.
Oldham, Mrs. J. P., 612 Goliad.
Owens, Mrs. Ross, 304 Barrett.
Oxford, Mrs. J. W. (Assoc.), Floresville.
Parsons, Mrs. John C., 131 W. Ridgewood.
Partain, Mrs. R. A., 201 Morningside Dr.
Paschal, Mrs. Frank L., 403 Maverick St.
Paschal, Mrs. George, 411 Maverick St.
Passmore, Mrs. B. H., 416 Maverick St.
Passmore, Mrs. G. G.
Pinson, Mrs. C. C., 910 Cambridge Oval.
Pipkin, Mrs. J. Lewis, 511 Brackenridge.
Pomerantz, Mrs. A. (Assoc.), 268 E. Lullwood.
Pomerantz, Mrs. R. B., 232 W. Herminc.
Post, Mrs. S. Perry, 307 North Dr.
Poth, Mrs. D. O., 304 Charles Rd.
Potthast, Mrs. D. J., 419 King William St.
Pressly, Mrs. T. A., 408 Mary Louise Dr.
Pridgen, Mrs. J. L., 227 W. Huisache.
Pritchett, Mrs. B., 231 North Dr.
Pyterek, Mrs. A. B., 421 E. Olmos Dr.
Rabel, Mrs. John E., 130 Lamont.
Ramsdell, Mrs. M. A., 412 Harrison Ave.
Reily, Mrs. W. A., 365 Club Dr.
Reinarz, Mrs. B. H.
Reveley, Mrs. Hugh, 3320 W. Houston.
Reveley, Mrs. James E. L., 727 Chicago.
Rhea, Mrs. R. L. (Assoc.), 515 Belknap.
Rhea, Mrs. R. L., Jr., 304 E. Courtland.
Rice, Mrs. Lee, 343 W. Gramercy Pl.
Ritch, Mrs. Allen, 221 Devine Rd.
Roan, Mrs. Omar, 107 Geneseo Rd.
Roberts, Mrs. R. A., N. Loop Rd.
Robertson, Mrs. Wilber, 540 Lamont.
Rosebrough, Mrs. F. H., 1040 W. Woodlawn.
Rosenzweig, Mrs. M. M., 104 Ridgewood.
Ross, Mrs. Lloyd L., 122 Canterbury.
Ross, Mrs. R. R., St. Anthony Hotel.
Russ, Mrs. Stirling E., 311 Howard.
Russ, Mrs. W. B., 1301 Belknap.
Russell, Mrs. Dan A., 600 Patterson.
Saegert, Mrs. A. H., 124 E. Edgewood.
Sample, Mrs. Roy O., 207 Park Lane.
Schattenberg, Mrs. H. J., 111 Queen Crescent.
Schwartzberg, Mrs. Sam, 110 Auditorium Circle.
Scott, Mrs. R. E., 315 Cloverleaf.
Scott, Mrs. R. J., 1212 Maverick St.
Scull, Mrs. C. E., 115 Paseo Encinal.
Scull, Mrs. T. J., 115 Paseo Encinal.
Severance, Mrs. A. O., 151 Harrison Ave.
Sharp, Mrs. T. H., 126 Park Hill Dr.
Shaver, Mrs. P. J. (Assoc.), 1401 Club Dr.
Shepherd, Mrs. W. F., 1401 Highland Blvd.
Shipman, Mrs. E. D., 551 Cincinnati.
Shotts, Mrs. C. C., 254 Retama.
Skinner, Mrs. I. C., 418 Russell Pl.
Sorell, Mrs. Frank W., 421 W. Lynwood.
Stansell, Mrs. Paul, 1930 W. Magnolia.
Steed, Mrs. Frank, 433 Mary Louise Dr.
Steele, Mrs. J. S. (Assoc.), 126 W. Woodlawn.
Steele, Mrs. Virgil, 155 Harrison Ave.
Steinberg, Mrs. F. W., 237 Castano.
Stieler, Mrs. Albert, 315 Club Dr.
Stout, Mrs. B. F., 110 W. Lynwood.
Stuck, Mrs. W. G., 312 Cardinal.
Sugg, Mrs. W. R., 218 Morningside Dr.
Sutton, Mrs. R. S., 710 W. Kirk.
Sweet, Mrs. Horace, 233 W. Summit.
Swinny, Mrs. Boen, 2611 San Pedro.
Sykes, Mrs. E. M., 201 Charles Rd.
Taylor, Mrs. C. W., 276 W. Mandalay Dr.
Taylor, Mrs. Sam, 343 W. Hollywood.
Templeton, Mrs. R. D., 332 Kendalia.
Tennison, Mrs. Charles W., 221 Primrose.
Thomas, Mrs. R. P., 234 Rosemary.
Timmins, Mrs. O. H., 928 W. Agarita.
Todd, Mrs. D. A., 305 Thelma Dr.
Tucker, Mrs. Victor, 2110 W. Kings Highway.
Turnbull, Mrs. E. (Assoc.), 146 Harrigan Court.
Urrutia, Mrs. Adolfo, 330 Rosemary.
Venable, Mrs. Charles S., 154 Park Hill Dr.
Venable, Mrs. J. Manning, 139 Park Hill Dr.
Walker, Mrs. E. (Assoc.), 2450 E. Houston St.
Walsh, Mrs. F. P. (Assoc.), Hunt.
Walthall, Mrs. Walter, 316 Maverick St.
Watts, Mrs. J. A., 433 W. Woodlawn.
Weatherford, Mrs. E. W., 331 Castano.
Weatherford, Mrs. F. W. (Assoc..), 410 Lynwood.
Weinfield, Mrs. L. M., 114 Natalen.
Weiss, Mrs. Victor J., 1419 Schley.
Wessels, Mrs. Andrew, 130 Oakmont.
West, Mrs. Albert, Jr. (Assoc.), Vance Jackson Rd.
Whitacre, Mrs. Stanley, 228 Alamosa.
Williams, Mrs. V. H., 112 Cloverleaf.
Winters, Mrs. J. W., 423 Dickman Rd.
Wolff, Mrs. W. M., 415 W. Ashby.
Worsham, Mrs. J. W.
Wright, Mrs. Rennie (Assoc.), New Braunfels.
Wyatt, Mrs. Byron W.
Wyneken, Mrs. H. O., 1105 W. French Pl.

KERR-KENDALL-GILLESPIE-BANDERA COUNTIES AUXILIARY*

Allison, Mrs. A. P.
Black, Mrs. A. J.
Bruce, Mrs. Paul C., Legion.
Culver, Mrs. C. F.
Domingues, Mrs. P. J.
Feller, Mrs. L. A., Fredericksburg.
Gallatin, Mrs. H. H.
Green, Mrs. Mara.
Gregg, Mrs. W. E.
Jackson, Mrs. J. D.
Jones, Mrs. C. C., Comfort.
Keidel, Mrs. Victor, Fredericksburg.
Keyser, Mrs. L. L., Fredericksburg.
Knapp, Mrs. D. R.
Koerth, Mrs. C. J.
McClellan, Mrs. C. L.
McCullough, Mrs. Davis
Matthews, Mrs. C. B.
Packard, Mrs. Duane
Perry, Mrs. J. H., Fredericksburg.
Pfeiffer, Mrs. H. G., Fredericksburg.
Reid, Mrs. H. P., Legion.
Secor, Mrs. W. L.
Swayze, Mrs. H. Y.
Thompson, Mrs. S. E.
Tubbs, Mrs. H. A., Fredericksburg.

MEMBERS-AT-LARGE, FIFTH DISTRICT

Barnard, Mrs. W. L., Carrizo Springs.
Davis, Mrs. Hugh, P. O. Box 607, Seguin.
Goodnight, Mrs. J. E., P. O. Box 275, Pearsall.
Hinman, Mrs. A. J., 225½ W. San Antonio, New Braunfels.
La Forge, Mrs. Hershall, Uvalde.
Lightsey, Mrs. J. N., Cotulla.
McWilliams, Mrs. W. R., Del Rio.

*Address is Kerrville unless otherwise stated.

Meredith, Mrs. W. P., 408 East Sixth, Del Rio.
Montemayor, Mrs. R. M., 925 Second St., Eagle Pass.
Oxford, Mrs. J. W., P. O. Box 186, Floresville.
Randolph, Mrs. V. P., Schertz.
Utterback, Mrs. A. P., Brackettville.
Ware, Mrs. T. P., Poteet.
Williams, Mrs. James D., Castroville.

SIXTH OR CORPUS CHRISTI DISTRICT

Mrs. P. H. Frenzel
Donna
Council Woman

CAMERON-WILLACY COUNTIES AUXILIARY

Allen, Mrs. G. Earl, 1415 E. 1st, Harlingen.
Ashcraft, Mrs. E. J., 409 E. Harrison, Harlingen.
Baden, Mrs. E. E., 522 E. Gem, Raymondville.
Bleakney, Mrs. Phil A., 219 E. Arroyo Dr., Harlingen.
Casey, Mrs. J. D., 104 N. Shore Dr., San Benito.
Cash, Mrs. C. M., 258 N. Austin, San Benito.
Dawson, Mrs. C. D., 898 N. Sam Houston, San Benito.
Galleher, Mrs. George L., 802 W. Lincoln, Harlingen.
Harrop, Mrs. L. Louis, 322 E. Monroe, Harlingen.
Hockaday, Mrs. J. A., 1120 Garcia, Port Isabel.
Pilmer, Mrs. Gordon A., 113 W. Roosevelt, Harlingen.
Shafer, Mrs. Troy A., 1101 E. Harrison, Harlingen.
Utley, Mrs. R. E., 215 S. 5th, Harlingen.
Watkins, Mrs. J. C., 522 E. Jackson, Harlingen.

HIDALGO-STARR COUNTIES AUXILIARY

Frenzel, Mrs. P. H., Donna.
Glass, Mrs. T. W., Weslaco.
Homme, Mrs. C. J., Edinburg.
Homme, Mrs. R. E., Edinburg.
Ice, Mrs. Noel, McAllen.
May, Mrs. J. W., Edinburg.
Moore, Mrs. L. H., McAllen.
Osborn, Mrs. Alfred, McAllen.
Pence, Mrs. R. W., San Juan.
Southwick, Mrs. L. M., Edinburg.
Sybilreed, Mrs. H. W., McAllen.
Tupper, Mrs. L. N., Elsa.
Walker, Mrs. O., Mission.
Webb, Mrs. J. G., Mercedes.
Wells, Mrs. E., Weslaco.
Whigham, Mrs. W. E., McAllen.

NUECES COUNTY AUXILIARY*

Averback, Mrs. B. F., 327 Louisiana.
Barnard, Mrs. W. C., 3209 Up River Rd.
Bickley, Mrs. E. T., 211 Indiana.
Blair, Mrs. J. V., 3709 Up River Rd.
Boettger, Mrs. H. F., 279 W. Longview.
Brown, Mrs. W. R., Nixon Bldg.
Carter, Mrs. N. D., 425 Del Mar.
Cline, Mrs. W. B., 3706 Santa Fe.
Colyer, Mrs. George, 306 Clifford.
Crain, Mrs. C. F., 704 Craig.
Danford, Mrs. E. A., 230 Indiana.
Davis, Mrs. W. T., 641 Atlantic.
Eckhardt, Mrs. K., 1222 6th.
Edgerton, Mrs. G. W., 3005 Lawnview.
Edwards, Mrs. T. W., 329 Southern.
Ellis, Mrs. Frank A., 339 Cole.
Furman, Mrs. McIver, 310 Atlantic.
Gaddis, Mrs. H. W., 3033 Lawnview.
Garret, Mrs. L. M., 2850 Topeka.
Gentry, Mrs. W. H., 1726 2nd.
Gibson, Mrs. N. T., Robstown.
Giles, Mrs. Jack, (Service)
Gill, Mrs. E. K. (Service)
Graham, Mrs. R. H., Robert Driscoll.
Grossman, Mrs. D. N. (Service)
Grossman, Mrs. Saul, 155 Rosseter.
Guttman, Mrs. L. E., 3418 Ocean Dr.
Horbaly, Mrs. W. M., 3402 Granada.
Hyder, Mrs. P. L., 145 Southern.
Janssen, Mrs. L. W. O., Clifford.
Jasperson, Mrs. C. P., 3201 Up River Rd.
Kemp, Mrs. K. J., 505 Naples.
Koepsel, Mrs. O. S. (Service)
Lloyd, Mrs. R. S., 641 Southern.

*Address is Corpus Christi unless otherwise stated.

McLaughlin, Mrs. R. S., 1301 Ocean Dr.
Marler, Mrs. Otis E., 237 Norton.
Martin, Mrs. S. B., 128 Del Mar.
Mathis, Mrs. E. G., 1116 2nd.
Meador, Mrs. C. N., 337 Naples.
Moller, Mrs. G. T., 334 Laurel Dr.
Moody, Mrs. Foy, 449 Indiana.
Morgan, Mrs. Charles G., 156 Santa Barbara.
Nast, Mrs. Jerome, 807 Craig.
O'Byrne, Mrs. G. T., 1227 3rd.
Olliphant, Mrs. T. H., 3142 Austin.
Perkins, Mrs. M. J., 221 Rosebud.
Pilcher, Mrs. Maurine, 323 Louise Dr.
Rosenheim, Mrs. Phillip, 130 W. Vanderbilt.
Roundtree, Mrs. J. T., 2306 Niagara.
Sharp, Mrs. James, N. Saxet Dr.
Sloan, Mrs. J. J. (Service)
Sloan, Mrs. J. M. (Service)
Smith, Mrs. Y. C., 340 Katherine.
Stewart, Mrs. C. D., 114 E. Vanderbilt.
St. John, Mrs. R. V., 225 Indiana.
Stroud, Mrs. S. K. (Service)
Swearingen, Mrs. R. G., 321 S. Morningside.
Thomas, Mrs. J. R., 702 Morgan.
Triplett, Mrs. William C. (Service)
White, Mrs. H. A., 711 N. Tancahua.
Yeager, Mrs. C. P., 312 Merril Dr.

SEVENTH OR AUSTIN DISTRICT

Mrs. T. J. McElhenney
Austin, Texas
Council Woman

CALDWELL COUNTY AUXILIARY

Coopwood, Mrs. Joe B., Lockhart.
DuBoise, Mrs. O. K., Lockhart.
Nichols, Mrs. Clay, Jr., Luling.
O'Banion, Mrs. J. T., Luling.
Pitts, Mrs. M. W., Luling.
Ross, Mrs. Abner A., Lockhart.
Smith, Mrs. Edgar, Lockhart.
Watkins, Mrs. Pruett, Luling.

HAYS-BLANCO COUNTIES AUXILIARY*

De Steiguer, Mrs. John R., 722 Voila St.
Edwards, Mrs. Louis L., 608 Hopkins St.
Flannery, Mrs. John L., Blanco.
Heatley, Mrs. M. D., 317 Blanco St.
Lauderdale, Mrs. Clay, Buda.
Morton, Mrs. John R., 832 Belvin St.
Pritchett, Mrs. John E., 816 Belvin St.
Roberts, Mrs. Joseph T., 802 Belvin St.
Sowell, Mrs. Rugel F., 1207 Belvin St.
Tabler, Mrs. L. O., 527 W. San Antonio St.
Vogelsang, Mrs. Peter, 609 Guadalupe St.
White, Mrs. L. M., 713 Burleson St.
Williams, Mrs. Milton C., 810 San Antonio St.

TRAVIS COUNTY AUXILIARY†

Bailey, Mrs. Joe, 408 W. 32nd St.
Bintliff, Mrs. Charles, 605 W. 14th St.
Black, Mrs. W. B., 401 W. 32nd St.
Blaustone, Mrs. H. H., 3110 West Ave.
Bohls, Mrs. S. W., 803 E. 32nd St.
Brown, Mrs. M. I., 2509 Indian Trail.
Brownlee, Mrs. C. H., 1901 W. 35th St.
Carter, Mrs. C. E., 603 Carolyn.
Chauvin, Mrs. E. V., 2210 Enfield Rd.
Chrisman, Mrs. W. P., Jr., 1602 Preston.
Cleveland, Mrs. C. W., 1101 Eason.
Cloud, Mrs. R. E., 48 Summit View.
Covington, Mrs. C. M., 605 E. 38th St.
Cooper, Mrs. R. A., 106 W. 13th St.
Cox, Mrs. George, 1512 Forest Trail.
Crockett, Mrs. J. A., 2519 Exposition Blvd.
Darnall, Mrs. C. M., 2805 Wooldridge Dr.
Davis, Mrs. W. A., 2408 Vista Dr.
Dildy, Mrs. C. B., 608 Harthan.
Dryden, Mrs. S. H., 1712 Newfield Lane.
Eckhardt, Mrs. J. W., 810 Avondale Rd.
Eckhardt, Mrs. Joe, 2300 Rio Grande.
Esquivel, Mrs. Sandy, 2306 Townes Lane.
Gambrell, Mrs. W. M., 2608 Harris Blvd.
Gibson, Mrs. J. W., 3406 Duval.
Gilbert, Mrs. Joe, 1402 West Ave.
Granberry, Mrs. H. B., 912 W. 6th St.
Gregg, Mrs. Banner, 2100 Parkway.
Hanna, Mrs. Ralph, 303 W. 9th St.
Harris, Mrs. W. W., 1410 Nickerson.
Helm, Mrs. Fred, 1626 Palma Plaza.
Henry, Mrs. H. B., 3107 Grandview.
Holtz, Mrs. H. E., 804 Rutherford Pl.

*Address is San Marcos unless otherwise stated.
†Address is Austin unless otherwise stated.

Howze, Mrs. J. E., 308 W. 12th St.
Hudson, Mrs. S. E., 706 San Antonio.
Jackson, Mrs. N. R., 1006 Gaston Ave.
Johnson, Mrs. J. E., 2203 Robinhood Trail.
Key, Mrs. Sam N., 2314 Woodlawn Blvd.
Klint, Mrs. Hugo, 311 W. 13th St.
Klotz, Mrs. H. L., 2200 Griswell Lane.
Kreisle, Mrs. M. F., 811 W. 31st St.
Krueger, Mrs. E., 310 E. 9th St.
Litton, Mrs. F., 1007 Shelley Lane.
McCrummen, Mrs. T. D., 2300 Windsor Rd.
McElhenney, Mrs. T. J., 1511 Rainbow Bend.
Middlebrook, Mrs. R. M., 2800 Enfield Rd.
Morgan, Mrs. W. P., 2204 Enfield Rd.
Morris, Mrs. T. N., 1403 Kent Lane.
Murray, Mrs. R. V., 408 W 32nd St.
Nanney, Mrs. A. L., 3005 Bridle Path.
Neighbors, Mrs. A. H., 1803 West Ave.
Niehols, Mrs. J. R., 800 Rio Grande.
Paggi, Mrs. L. C., 2604 Harris Blvd.
Paine, Mrs. H. C., 3601 Windsor Rd.
Perkins, Mrs. Clay, 807 Leonard.
Post, Mrs. G. W., 406½ W. 13th St.
Primer, Mrs. B. M., 2709 Rio Grande.
Rice, Mrs. Albert J., 3212 Windsor Rd.
Richardson, Mrs. Dalton, 1111 W. 11th St.
Robison, Mrs. J. T., Gaston Ave.
Schiller, Mrs. N. L., 1606 Preston.
Scott, Mrs. H. A., 1208 W. 22½ St.
Smith, Mrs. Howard, 1508 W. 30th St.
Terry, Mrs. A. A., 2000 Parkway.
Thomas, Mrs. J. C., 3 Niles Rd.
Wade, Mrs. David, 2107 Woodmont.
Walter, Mrs. L. P., 2012 Enfield Rd.
Watt, Mrs. T. N., 1106 Colorado.
Watt, Mrs. Will, 1502 Marshall Lane.
White, Mrs. B. O., 1706 W. 31st.
Williams, Mrs. Harriss, 2505 McCallum Dr.
Wilson, Mrs. R. T., 2506 Spring Lane.
Woolsey, Mrs. S. A., 509 W. 12th St.

MEMBERS-AT-LARGE, SEVENTH DISTRICT

Atkinson, Mrs. O. B., Florence.
Bryson, Mrs. J. Gordon, Bastrop.
Gregg, Mrs. D. B., Round Rock.
Hock, Mrs. Charles M., Smithville.
Hock, Mrs. C. M., Smithville.
Johns, Mrs. Jay J., Taylor.
Kirkpatrick, Mrs. B. A., Taylor.
Kroulik, Mrs. Frank J., Smithville.
Lauderdale, Mrs. Clay, Box 555, Buda.
Mantzel, Mrs. S. W., Box 187, Giddings.
Martin, Mrs. John R., Georgetown.
Stromberg, Mrs. Eric W., 1301 Lexington St., Taylor.
Zork, Mrs. W. E., Giddings.

EIGHTH OR DeWITT DISTRICT

Mrs. F. J. L. Blasingame
Wharton
Council Woman

DeWITT-LAVACA COUNTIES AUXILIARY

Bohman, Mrs. A. J., Cuero.
Blackwell, Mrs. F. D., Hochheim.
Brown, Mrs. H. H., Jr., Yoakum.
Brown, Mrs. H. H., Sr., Yoakum.
Burns, Mrs. J. G., Cuero.
Burns, Mrs. J. W., Cuero.
Dobbs, Mrs. J. C., Cuero.
Douthit, Mrs. W. E., Cuero.
Duckworth, Mrs. Marvin, Cuero.
Dufner, Mrs. C. T., Hallettsville.
Gray, Mrs. J. D., Cuero.
Jaeggli, Mrs. Sam, Moulton.
Kopecky, Mrs. C. L., Shiner.
Marek, Mrs. E. H., Yoakum.
Milner, Mrs. R. M., Yoakum.
Nowierski, Mrs. Leon, Yorktown.
Pridgen, Mrs. J. H., Cuero.
Pulkrabek, Mrs. E. H., Yoakum.
Renger, Mrs. H., Hallettsville.
Renger, Mrs. Paul, Jr., Hallettsville.
Renger, Mrs. Paul, Sr., Hallettsville.
Richter, Mrs. L. B. S., Yoakum.
Strieber, Mrs. H. J., Moulton.
Wagner, Mrs. F. M., Shiner.

WHARTON-JACKSON-MATAGORDA-FORT BEND COUNTIES AUXILIARY

Bauknight, Mrs. J. M., Gonado.
Blaek, Mrs. V. A., Wharton.
Blair, Mrs. W. M., Wharton.
Blasingame, Mrs. F. J. L., Wharton.
Brewer, Mrs. Paul, Bay City.
Byrd, Mrs. Wallace, Wharton.
Davidson, Mrs. G. L., Wharton.

Davidson, Mrs. T. L., Wharton.
Guffy, Mrs. J. L., El Campo.
Johnson, Mrs. R. G., Newgulf.
McGee, Mrs. B. M., Rosenberg.
Nese, Mrs. T. M., Wharton.
Nichols, Mrs. C. V., Richmond.
Outlar, Mrs. L. B., Wharton.
Reeves, Mrs. H. V., El Campo.
Rugeley, Mrs. F. R., Wharton.
Schulze, Mrs. G. A., El Campo.
Shoultz, Mrs. C. A., Bay City.
Simons, Mrs. B. E., Bay City.
Simons, Mrs. J. W., Newgulf.
Thiltgen, Mrs. W. S., El Campo.
Weinheimer, Mrs. E. A., El Campo.
Whitfield, Mrs. W. E., Edna.
Williams, Mrs. J. E., Wharton.
Zipp, Mrs. R. D., Edna.

MEMBERS-AT-LARGE, EIGHTH DISTRICT

Allen, Mrs. G. W., Jr., San Antonio.
Boelsche, Mrs. Leslie D., La Grange.
DeTar, Mrs. W. T., Victoria.
Ehlert, Mrs. Edward, Victoria.
Guenther, Mrs. Frank J., La Grange.
Hopkins, Mrs. J. V., Victoria.
Kirkham, Mrs. S. H., Columbus.
Laughlin, Mrs. John R., Eagle Lake.
Miller, Mrs. A. C., Carmine.
Owen, Mrs. Adrian, Victoria.
Peters, Mrs. Leo J., Schulenburg.
Potthast, Mrs. A. H., Weimar.
Shields, Mrs. Allan, Victoria.

NINTH OR SOUTHERN DISTRICT

Mrs. Jesse B. Johnson
Galveston
Council Woman

AUSTIN-WALLER COUNTIES AUXILIARY

Brown, Mrs. W. T., Wallis.
Gordon, Mrs. V., Sealy.
Hover, Mrs. F. W., Sealy.
Neely, Mrs. J. A., Bellville.
Roensch, Mrs. H. E., Bellville.
Steck, Mrs. O. E., Bellville.
Walker, Mrs. S. C., Hempstead.

BRAZORIA COUNTY AUXILIARY

Cox, Mrs. Walter E., Angleton.
Gray, Mrs. Ralph E., Lake Jackson.
Greenwood, Mrs. W. M., West Columbia.
Hayes, Mrs. G. J., Alvin.
Holt, Mrs. William C., Angleton.
McCary, Mrs. A. O., Freeport.
McCary, Mrs. R. M., Freeport.
Merz, Mrs. H. E., Alvin.
Miller, Mrs. R. C., Lake Jackson.
Muetz, Mrs. Walter, Pearland.
Reeves, Mrs. George D., Freeport.
Ryan, Mrs. W. G., Freeport.
Slaughter, Mrs. S. B., Freeport.

GALVESTON COUNTY AUXILIARY*

Anderson, Mrs. W. T., La Marque.
Aves, Mrs. Fred, Dickinson.
Beeles, Mrs. George W., 417 10th Ave. N, Texas City.
Bodansky, Mrs. Meyer, 3712 Ave. P½.
Brindley, Mrs. Paul, 4306 Sherman.
Chapman, Mrs. L. E., 3202 Ave. Q.
Cone, Mrs. R. D., 2602 Ave. O.
Cooke, Mrs. W. R., 4510 Caduceus.
Cruce, Mrs. W. B., 919 18th Ave. N., Texas City.
Danforth, Mrs. F. N., 18 9th Ave. N., Texas City.
Decherd, Mrs. George M., 5023 Ave. N½.
Delaney, Mrs. John J.
Eggers, Mrs. G. W. N., 4625 Caduceus.
Ewalt, Mrs. Jack R., 24 Cedar Lawn N.
Fisher, Mrs. W. C., Jr., 3214 Ave. P.
Flautt, Mrs. J. A., 1805 18th.
Fowles, Mrs. Frederick, 3509 Ave. P.
Frank, Mrs. T., Texas City.
Frazier, Mrs. C. N., 3807 R.
Gammon, Mrs. William, 63 Cedar Lawn Circle.
Garbade, Mrs. F. A., 4515 Ave. N.
Gilliam, Mrs. Hughes, 4818 Sherman.
Gregory, Mrs. Raymond, 1419 24th.
Hansen, Mrs. Arild E., 4319 Caduceus.
Harris, Mrs. L. R., 702 Market.
Harris, Mrs. Sarah, 2723 Broadway.
Harris, Mrs. Titus, 1428 Broadway.
Herrmann, Mrs. George, 1409 Market.

*Address is Galveston unless otherwise stated.

Jarrell, Mrs. Norman, 304 9th Ave., Texas City.
Jinkins, Mrs. A. J., 5101 S½.
Jinkins, Mrs. J. L., 3121 Ave. P.
Jinkins, Mrs. W. J., Sr., 2827 Ave. O.
Johnson, Mrs. Jesse B., 4627 Sherman.
Klatt, Mrs. Emil H., 3815 Ave P.
Kleburg, Mrs. Walter, 2221 35th.
Knight, Mrs. H. O., 3120 Ave. Q.
Kolb, Mrs. Weldon, 4900 Wharton.
Lee, Mrs. George T., 4600 Caduceus.
Lefeber, Mrs. Edward J., 1202 Ball.
Levin, Mrs. William C., 4828 Wharton.
McGivney, Mrs. John, 5005 Crockett.
McLarty, Mrs. E. S., Buccaneer Hotel.
McReynolds, Mrs. George S., 20 Cedar Lawn Circle.
Magliolo, Mrs. J. C., Dickinson.
Manske, Mrs. Gerald R., Texas City.
Mares, Mrs. C. F., 4802 Denver.
Marr, Mrs. William, 11 Cedar Lawn Circle.
Moore, Mrs. Robert M., 1720 Ball.
Otto, Mrs. John, 4802 Sherman.
Perlman, Mrs. Bernard, 2301 39th.
Peters, Mrs. Leo J., 915 17th Ave., Texas City.
Poetter, Mrs. H. W., S. S. Galveston Apts.
Potter, Mrs. W. B., 4519 Woodrow.
Randall, Mrs. Edward, Jr., 3502 Ave. P.
Randall, Mrs. Edward, Sr., 2004 Broadway.
Ritchie, Mrs. E. B., 4804 Sherman.
Robinson, Mrs. H. Reid, 3420 Ave. O.
Ross, La Mar, 4627 Ave. R½.
Ruskin, Mrs. Arthur, 3614 R½.
Schmidt, Mrs. H. A., 113 10th Ave., Texas City.
Schwab, Mrs. Edward, 2 Cedar Lawn.
Sharp, Mrs. William B., 1724 Boulevard.
Singleton, Mrs. A. O., 1602 Broadway.
Slocum, Mrs. H. C., 5126 Ave. U.
Snodgrass, Mrs. S. R., 1217 Market.
Stone, Mrs. C. T., 11 Cedar Lawn N.
Sweets, Mrs. H. H., Jr., 915 8th St.
Sykes, Mrs. Clarence, 4628 Sherman.
Thiel, Mrs. John, 3801 O½.
Thompson, Mrs. E. R., 1516 Broadway.
Twidwell, Mrs. Leonard, Texas City.
Wall, Mrs. Dick P., 1202 Broadway.
Wallace, Mrs. W. S., 2525 Broadway.
Weinert, Mrs. Herman, 5001 Crockett.
Weisz, Mrs. Stephen, 1002 Broadway.

HARRIS COUNTY AUXILIARY*

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Adams, Mrs. Granville Q., 1932 Dryden.
Alexander, Mrs. H. L., 3210 Parkwood.
Alexander, Mrs. J. C., 1601 S. Shepherd.
Andrews, Mrs. Tom A.
Armentrout, Mrs. Coral R., 3229 Calumet.
Arnold, Mrs. Enga M., 2536 Prospect.
Ashmore, Mrs. C. M., 2027 Addison Rd.
Austraw, Mrs. H. H., 2224 Dorrington Rd.
Aydam, Mrs. Charles W., 307 W. Pierce.
Baird Mrs. Val C., 3701 Del Monte.
Barkley, Mrs. Howard T., 4104 Garrott.
Barnes, Mrs. J. Peyton, 3651 Olympia.
Barrett, Mrs. John H., 1841 Palm.
Bayer, Mrs. B. H., 1132 Heights Blvd.
Bell, Mrs. J. E., 3344 Charleston.
Bell, Mrs. William E., 1927 Norfolk.
Berry, Mrs. C. R., 3202 Oakmont.
Bertner, Mrs. E. W., Rice Hotel.
Best, Mrs. Paul W., Warwick Hotel.
Billups, Mrs. J. T., 2302 Southmore.
Biscoe, Mrs. Pat, 4373 N. MacGregor Way.
Blair, Mrs. Lyman C., 3406 Georgetown.
Blair, Mrs. Robert K., 3214 Ewing.
Bloom, Mrs. Fred A.
Bloxsom, Mrs. Allan P., 2240 Chilton.
Blundell, Mrs. J. Reese, 2220 Stanmore.
Bost, Mrs. J. R., 2941 Chevy Chase.
Bourdon, Mrs. Lynn L., 2315 Watts.
Bowen, Mrs. Ralph, 3509 Montrose.
Bowen, Mrs. Shirley, 2536 Westgate Dr.
Boyd, Mrs. A. N., 3117 Avalon.
Braden, Mrs. A. H., 2351 Kelvin.
Bradford, Mrs. Keith F.
Brady, Mrs. R. J., 605 E. Cottage.
Brandau, Mrs. George H., 409 Polk.
Brandes, Mrs. E. B., Plaza Hotel.
Brannon, Mrs. Jack G., 119 W. Alabama.
Bressler, Mrs. J. L., 2346 Tangley.
Brohn, Mrs. Alfred J., 103 Morris.
Brown, Mrs. James A., 710 Pacific.
Brown, Mrs. John W.
Bruder, Mrs. Wood H., 245 W. 18th.
Bruhl, Mrs. Charles E., 1706 North Blvd.
Bruhl, Mrs. Charles K., 1706 North Blvd.
Bryan, Mrs. W. G., 4820 San Jacinto.
Bukowski, Mrs. Lucian M., 2203 Dunrayen.

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Burge, Mrs. Curtis, 2214 North Blvd.
Burr, Mrs. Harry B., 6407 Peerless.
Burke, Mrs. Thomas W., 3402 Wickersham.
Calhoun, Mrs. C. Alsworth, 2152 Pelham.
Caplowitz, Mrs. H., 2102 Tangley.
Carrico, Mrs. Carl C.
Chapman, Mrs. Dan W., 1220 Bartlett.
Chunn, Mrs. E. K., 2433 Glenhaven.
Clapp, Mrs. J. Alston.
Clarke, Mrs. Herndon H., 2015 Dryden.
Clarke, Mrs. Jared E., 2124 Inwood.
Cohen, Mrs. Raymond, 709 Avondale.
Cole, Mrs. W. Frank, 3201 Amherst.
Collette, Mrs. Allen, 1002 Bissonnet.
Compere, Mrs. T. H., 2631 Fenwood.
Connor, Mrs. W. Harris, 2910 Sunset Blvd.
Coogle, Mrs. C. P., 2220 Maroneal.
Coole, Mrs. Walter A., 102 Portland.
Coop, Mrs. B. F., 1536 Heights Blvd.
Cope, Mrs. R. Louis, 6605 Meadow Lawn.
Coulter, Mrs. W. W., 1705 Ewing.
Crapitto, Mrs. Louis A., 108 Oak Pl.
Crigler, Mrs. Cecil M., 3617 Olympia.
Crocker, Mrs. Ed, 2906 Wichita.
Cronin, Mrs. Thomas D., 2131 Maroneal.
Cummings, Mrs. Hatch W.
Cunningham, Mrs. G. N., 2106 Colquitt.
Curb, Mrs. Dolph.
Cutler, Mrs. Hayden H.
Cruse, Mrs. P. R., 2440 Del Monte.
Dailey, Mrs. J. Emerson.
Daniel, Mrs. Joe E., 4500 Rossmoyne.
Dargan, Mrs. J. L., 2008 Milford.
Davis, Mrs. C. Q., 1204 Wentworth.
Denman, Mrs. Peyton R., 1220 Southmore.
DeVore, Mrs. Neal M., 1971 W. McKinley.
Dickson, Mrs. J. Charles, 5310 Mandell.
Dippel, Mrs. A. Louis, 2521 Stanmore.
Doak, Mrs. N. P., 2230 Branard.
Donovan, Mrs. Thomas J.
Duggan, Mrs. LeRoy, 401 Colquitt.
Dunkerly, Mrs. Allen K., 5518 Jackson.
Dustin, Mrs. Herman E., 1118 Wheeler.
Durrance, Mrs. F. Y., 2124 Albans.
Doak, Mrs. Edmond K., 2105 Dunstan.
Durham, Mrs. Mylie E., 730 W. 43rd.
Ehlers, Mrs. H. J., 2112 Brentwood.
David, Mrs. S. D., 4003 Mount Vernon.
Eidman, Mrs. F. G., 1449 Lawson.
Embree, Mrs. Elisha D., 1915 Branard.
Englehardt, Mrs. H. A., 2208 Southmore.
Englehardt, Mrs. H. T., 5415 Austin.
Ernst, Mrs. Frank, 4313 Rossmoyne.
Estes, Mrs. Berthold, 3746 Darcus.
Farfel, Mrs. Bernard, 3342 Wichita.
Faris, Mrs. Arthur M., 2033 Norfolk.
Feagin, Mrs. Horace C., 3806 Garrott.
Filipone, Mrs. John M., 623 Hawthorne.
Finney, Mrs. R. Milton, 1936 Rice Blvd.
Fisher, Mrs. Wilton M., 3708 Arnold.
Flynt, Mrs. Otis P., 509 Avondale.
Foote, Mrs. Stephen A.
Ford, Mrs. W. A., 2238 Richmond.
Foster, Mrs. Joe B., 2002 Main.
Frachtman, Mrs. H. Julian, 5516 Chenevert.
Fitch, Mrs. Edward O., 1832 Kirby.
Freundlich, Mrs. Thomas, 419 Avondale.
Gandy, Mrs. D. Truett, Bunker Hill (RFD).
Gandy, Mrs. Joe R., 2104 Pine Valley.
Gardner, Mrs. Herman L., 2245 Maroneal.
Gaston, Mrs. John Zell, 2210 Riverside.
Gates, Mrs. Charles S., 3119 Avalon Pl.
Glenn, Mrs. John King, 4412 Montrose.
Goar, Mrs. E. L., 3203 Huntington.
Goodwin, Mrs. R. T., 1827 Kipling.
Graves, Mrs. Ghent, 3416 Garrott.
Graves, Mrs. M. L., 11 Shadowlawn.
Gready, Mrs. Donald M., 2420 Calumet.
Green, Mrs. C. C., 5328 Institute Lane.
Greene, Mrs. James A., 2512 Southmore.
Greenwood, Mrs. James, Jr., 3666 Chevy Chase.
Greenwood, Mrs. James, Rt. 3, Old Main St. Rd.
Greer, Mrs. Alvis E., 1715 North Blvd.
Greer, Mrs. Cecil, 7430 Harrisburg.
Griffey, Mrs. E. W., 2218 Troon.
Griswold, Mrs. C. M., 2121 Brentwood.
Grunbaum, Mrs. F. V., 2335 Maroneal.
Guthrie, Mrs. Thomas.
Haden, Mrs. Henry C., 3704 Montrose.
Haley, Mrs. S. Willard, 1915 Temple
Hamilton, Mrs. Carlos R., 5212 Caroline.
Handly, Mrs. L. L., 716 Alabama.
Hardy Mrs. S. Baron, 1406 Vassar.
Harris, Mrs. C. P., 11 Chelsea.
Harris, Mrs. Fred, 2404 Inwood.
Harris, Mrs. Herbert H.
Harris, Mrs. J. Wade, 2437 Brentwood.
Hauser, Mrs. A.
Heard, Mrs. J. Griffin, 3059 Reba.
Henderson, Mrs. Donald G.
Hild, Mrs. Jack, 2810 Caroline.

Hill, Mrs. Joel Milam.
Hinds, Mrs. Gordon F., 2207 Bolsover.
Hines, Mrs. Norman, 2322 Southgate.
Hodell, Mrs. George R., 2501 Dryden.
Hodges, Mrs. J. Edward, 2815 Main.
Hoeflich, Mrs. C. W., 1603 McGowen.
Holland, Mrs. T. L., 3838 Olympia.
Hollimon, Mrs. James H., 4518 Dixie.
Holloran, Mrs. R. J., 1115 Willard.
Hollub, Mrs. Charles J., 2702 Barbee.
Hotchkiss, Mrs. D. H., Jr.
Howard, Mrs. A. Philo, 3608 Audubon.
Hucherson, Mrs. Denman C., 1012 Rosedale.
Huffman, Mrs. M. M., 2215 North Blvd.
Hughes, Mrs. Fred M., 3604 University.
Iliams, Mrs. Frank J., 2346 MacGregor Way.
Johnson, Mrs. Herman W., 4510 Caroline.
Johnson, Mrs. R. Marion, 2152 Del Monte.
Johnston, Mrs. Robert A., 7 Shadowlawn.
Jones, Mrs. J. R.
Jorns, Mrs. C. Forrest, 4426 Pease.
Karbach. Mrs. Nelson W., 3205 Del Monte.
Karnaky, Mrs. Karl J., 3237 Binz.
Kennerly, Mrs. Thomas, 2437 Nottingham.
Kerr, Mrs. Denton, 1924 Braeswood.
Kilgore, Mrs. F. Hartman, 5320 Calhoun.
Kilgore, Mrs. Norris, 2347 Addison.
Kincaid, Mrs. Harvey L., 2423 Dryden.
Kirkham, Mrs. H. L. D.
Kirkpatrick, Mrs. L. P.
Klanke, Mrs. C. W.
Knoll, Mrs. Alfred F., 411 W. Alabama.
Knolle, Mrs. Guy E. 2028 Timber Lane.
Kyle, Mrs. J. Allen, 1702 Main.
Lancaster, Mrs. E. H., 2617 Riverside.
Lapat, Mrs. William, 2301 Maroneal.
Larsen, Mrs. Reuben L.
Latimer, Mrs. Mark H.
Lawrence, Mrs. B. A., 2905 Wichita.
Lechenger, Mrs. G. C., 4819 Caroline.
Ledbetter, Mrs. A. A., 3262 Reba.
Ledbetter, Mrs. Paul V., 3508 Inwood.
Levy, Mrs. M. D., 5302 Institute Lane.
Lewis, Mrs. Everett B.
Lewis, Mrs. L. R., Memorial Drive.
Liles, Mrs. Ralph, 5104 Caroline.
Lister, Mrs. S. M., 4209 Montrose.
Logue, Mrs. Lyle J., 3340 Del Monte.
Lowe, Mrs. T. E.
Lucas, Mrs. J. B., 421 W. 20th.
Lummis, Mrs. Fred R., 3921 Yoakum.
McAllister, Mrs. F. E., 5325 Institute Lane.
McCully, Mrs. J. Duncan, 2334 Tangley.
McDaniel, Mrs. Shaw.
McDeed, Mrs. W. G., 2111 Sunset.
McGehee, Mrs. F. O., 949 Kirby Dr.
McHenry, Mrs. R. K., 3660 Chevy Chase.
McIndoe, Mrs. Frank W., 2324 Dryden.
McKeever, Mrs. Duncan C., 2529 Reba.
McMeans, Mrs. R. H., 2217 Pelham.
McMurray, Mrs. Allen, 22 Briar Hollow Lane.
McNeill, Mrs. A. S., 1502 Hyde Park.
McReynolds, Mrs. I. S.
Madsen, Mrs. A. C., 5328 Calhoun.
Maresh, Mrs. Henry R., 2416 Riverside.
Maresh, Mrs. R. E., 1627 South Blvd.
Margraves, Mrs. R. D., 2428 Reba Dr.
Marshall, Mrs. Reagan
Martin, Mrs. James R.
Mayfield, Mrs. J. H., 4419 N. Roseneath.
Melton, Mrs. W. Truett.
Messer, Mrs. J. N., 2612 Calumet.
Miller, Mrs. A. L., 1245 Yale.
Milliken, Mrs. Gibbs, 3120 MacGregor Way.
Moers, Mrs. Edwin A., 3204 Shenandoah.
Molloy, Mrs. James P., 2624 Prospect.
Montgomery, Mrs. Charles F., 2225 Quinby.
Mood, Mrs. George F.
Moore, Mrs. John T., 1709 Sunset.
Morse, Mrs. Walter, 2215 Robinhood.
Moursund, Mrs. W. H., 2113 Milford.
Myers, Mrs. Claude D., 2104 Pelham.
Nester, Mrs. Charles R., 3440 Oakdale.
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Orman, Mrs. McDonald, 2335 Glen Haven.
Overgaard, Mrs. A. P., 3901 Austin.
Owen, Mrs. A. George, 612 Hathaway.
Page, Mrs. J. Herbert.
Parr, Mrs. L. H., 1510 McDuffie.
Parsons, Mrs. A. M., 6 W. Lane.
Patrick, Mrs. Ralph C., 5055 Calhoun.
Perdue, Mrs. George W., 2218 W. Main.
Peterson, Mrs. Henry A., 3919 Mount Vernon.
Phelps, Mrs. Kenton.
Phillips, Mrs. John Robert, 5806 Bayou Bend.
Pittman, Mrs. James E., 3220 Binz.
Podesta, Mrs. Louis N., 3830 Case.

Potts, Mrs. Charles R., 3 Briar Hollow Lane.
Powell, Mrs. Norborne B., 3002 San Felipe.
Poyner, Mrs. Herbert F., 2248 Chilton.
Prince, Mrs. Homer E., 2125 Bolsover.
Pugsley, Mrs. Cornelius.
Pulliam, Mrs. L. T., 1801 Harold.
Purdie, Mrs. Robert M., 6818 Staffordshire.
Qualtrough, Mrs. Walter F., 28 Briar Hollow Lane.
Rader, Mrs. John F., 3751 Charleston.
Ramsay, Mrs. W. E., 3616 Meadow Lake Lane.
Raney, Mrs. Lowel W., 2701 Fannin.
Ray, Mrs. John Wyeth, 3919 Palm.
Rèd, Mrs. W. S., Jr., 1936 Larchmont.
Reece, Mrs. Charles D., 2031 Banks.
Renfrow, Mrs. W. Frank, 2510 Del Monte.
Rives, Mrs. Hugh, 3 Dunlavy Court.
Robbins, Mrs. E. Freeman, 2916 Chevy Chase.
Robertson, Mrs. R. C. L., 2314 Braeswood Blvd.
Robinett, Mrs. James B., Jr., 3136 Oakdale.
Rohrer, Mrs. G. E., Jr., 2036 Danville.
Royce, Mrs. Thomas L., 1510 Colquitt.
Ruiz., Mrs. John J., 8246 Park Place Blvd.
Rumph, Mrs. Q.
Rushing, Mrs. John B., 5519 Ardmore.
Russell, Mrs. Thomas G., 1497 Lexington.
Sacco, Mrs. Allan C., Rt. 12, Box 464.
Salerno, Mrs. Joseph P., 1401 Vassar.
Salinger, Mrs. A., 3420 Roseland.
Salmon, Mrs. George W., 1220 Bartlett.
Sanders, Mrs. Charles B., 6 Courtland Pl.
Sanderson, Mrs. T. A.
Scardino, Mrs. P. H., 4520 Rossmoyne.
Schaffer, Mrs. Carl, 2421 Wordsworth.
Schilling, Mrs. John G., 2115 Arbor.
Schultz, Mrs. Jacob F., 3444 Locke Lane.
Seale, Mrs. Everett.
Sinclair, Mrs. T. A., 1801 Heights Blvd.
Skogland, Mrs. J. E., 3805 Marlowe.
Slataper, Mrs. F. J., 2001 Wentworth.
Smith, Mrs. B. F., 8 Chelsea.
Smith, Mrs. Burt B.
Smith, Mrs. Clifford, 2420 Brentwood.
Smith, Mrs. Edward T., 2120 Brentwood.
Smith, Mrs. J. Murray, 4361 Blodgett.
Spiller, Mrs. J. B., 4701 Austin.
Spurlock, Mrs. G. H., 3240 Del Monte.
Stackhouse, Mrs. H., Jr., 2331 Dryden.
Stalnaker, Mrs. Paul R., 5401 San Jacinto.
Stevenson, Mrs. W. M., 2423 Pelham.
Stork, Mrs. W. J., 3801 Fannin.
Stough, Mrs. John T., 2210 Dryden.
Strashun, Mrs. M. F.
Strassmann, Mrs. E. O., 2310 Binz.
Strozier, Mrs. W. M., 311 Kress Bldg.
Swetland, Mrs. D. R.
Tackaberry, Mrs. A. L. W., 324 Hathaway.
Talley, Mrs. A. T., 2128 Southmore.
Theriot, Mrs. J. Roy, Jr., 1205 Kenwood.
Thomas, Mrs. Charles, 805 Sul Ross.
Thorn, Mrs. S. W., 3140 Oakdale.
Thorning, Mrs. W. B., Jr.
Thorning, Mrs. W. B., Sr., 3602 Graustark.
Toland, Mrs. William A., 4501 Caroline.
Trible, Mrs. J. M., 2402 Calumet.
Truitt, Mrs. J. J., 2619 Grant.
Tucker, Mrs. J. Norris.
Turner, Mrs. B. Weems, 2947 Inwood.
Turner, Mrs. C. Gary.
Tusa, Mrs. Theo S., 1624 Richmond.
Tuttle, Mrs. L. L. D., 2223 Inwood.
Vanzant, Mrs. Thomas J., 2223 MacGregor Way.
Vaughn, Mrs. Luther M.
Wachsman, Mrs. David, 5510 Jackson.
Waldron, Mrs. George W., 3659 Inwood.
Wall, Mrs. John
Wallis, Mrs. Marshall, 2031 Sunset.
Ward, Mrs. Thomas E., 1605 Heights Blvd.
Warner, Mrs. Clyde M., 3256 Reba.
Warner, Mrs. Lucien M., 2912 Ella Lee Lane.
Weil, Mrs. Sol B., 2246 Dryden.
Weisinger, Mrs. Ross
Welch, Mrs. Hugh C., 218 W. Main.
Whitsitt, Mrs. J. J., 5312 Cherokee.
Wigby, Mrs. Palmer E., 2043 Goldsmith.
Wilkerson, Mrs. Edward A., 12 Chelsea.
Williford, Mrs. L. E., 2529 Youpon.
Wills, Mrs. Seward, 5327 Mandell.
Wilson, Mrs. Carl, 1512 W. Alabama.
Withers, Mrs. H. W., 2247 North Blvd.
Wolf, Mrs. E. Trowbridge.
Wootters, Mrs. John H., 2119 Pine Valley.
York, Mrs. Byron P.
Young, Mrs. Carl B., 3325 Del Monte.
Youngblood, Mrs. J. C., 3011 Ella Lee Lane.
Zarr, Mrs. Lynn, 3330 Del Monte.

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Hampil, Mrs. C. C., Brazoria.
McFarling, Mrs. J. E., Humble.
McWilliams, Mrs. H. K., Waller.
Pipkin, Mrs. R. W., Baytown.
Pope, Mrs. A. E. C., Crosby.
Sandlin, Mrs. J. W., Beaumont.
Stewart, Mrs. J. M., Katy.

WASHINGTON COUNTY AUXILIARY*

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Burnett, Mrs. M. D., 114 Sycamore.
Graber, Mrs. Fred, 409 W. Main.
Hasskarl, Mrs. Robert A., Box 696.
Hasskarl, Mrs. W. F., Box 357.
Heineke, Mrs. Gus, 1308 S. Austin.
Knolle, Mrs. Olga, 1008 Day St.
Knolle, Mrs. Roger E., 801 S. Clinton.
Knolle, Mrs. W. A., 511 Sycamore.
Kusch, Mrs. G. A. L., Gay Hill.
Lenert, Mrs. R. H., 604 S. Market.
Lusk, Mrs. Hugh, 415 W. Main.
Miller, Mrs. A. C., Carmine.
Pazdral, Mrs. G. V., Somerville.
Schoenvogel, Mrs. O. F., 112 Mulberry.
Simmons, Mrs. H. G., 617 School St.
Southern, Mrs. C. E., Burton.
Stafford, Mrs. S. E.
Steinbach, Mrs. H. L., 1310 S. Market.
Tottenham, Mrs. W. F., 704 E. Academy.
Toubin, Mrs. Sam, 712 W. Main.
Zeiss, Mrs. George, 201 E. Germania.

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Coker, Mrs. G. B., Tomball.
Corrigan, Mrs. Joseph, Conroe.
Gardner, Mrs. T. D., Livingston.
Grimes, Mrs. Ivison, Camden.
Hale, Mrs. D. M., Cold Springs.
Olive, Mrs. Roy A., Livingston.
Sanders, Mrs. G. C., Richards.
Stewart, Mrs. H. L., Navasota.

TENTH OR SOUTHEASTERN DISTRICT

Mrs. John Carter
Beaumont
Council Woman

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Burch, Mrs. Joe, 514 Frank.
Childers, Mrs. D. M., 119 E. Denman.
Clement, Mrs. J. C., 817 Mantooth.
Clements, Mrs. P. C., 912 S. 1st.
Denman, Mrs. Lenwood, 602 N. 1st.
Estep, Mrs. M. A., 715 Mantooth.
Evans, Mrs. F. M., 630 Montrose.
Gibson, Mrs. Mitchell O., 620 N. 2nd.
Hawkins, Mrs. J. W., 1002 Turner.
Klein, Mrs. Jim, Highway 94, Box 1216.
Stewart, Mrs. C. B., Huntington.
Sweatland, Mrs. A. E., 602 Frank.
Taylor, Mrs. Robert, 501 Jefferson.
Tinkle, Mrs. L. T., Houston Highway.
Wade, Mrs. J. H., 718 Frank.

HARDIN-TYLER COUNTIES AUXILIARY

Allums, Mrs. Joe Ada, Kountze.
Anderson, Mrs. W. W., Kountze.
Barclay, Mrs. Watt, Woodville.
Cline, Mrs. W. B., Sr., Woodville.
Cruse, Mrs. J. B., Woodville.
Darby, Mrs. T. O., Sour Lake.
Harrison, Mrs. A. W., Woodville.
Mann, Mrs. J. A., Colmesneil.
Poshataske, Mrs. W. J., Silsbee.
Shivers, Mrs. J. F., Woodville.
Tate, Mrs. R. A., Kountze.

JEFFERSON COUNTY AUXILIARY‡

Alexander, Mrs. H. E.
Autrey, Mrs. A. R., Port Arthur.
Barr, Mrs. R. E.
Bevil, Mrs. Harold
Bevil, Mrs. Grady
Boring, Mrs. C. W., Port Arthur.
Brandeau, Mrs. W. H.
Brown, Mrs. W. D.
Bybee, Mrs. J. A.
Byrd, Mrs. Leroy, Jr., Port Arthur.
Carger, Mrs. J. C.
Carter, Mrs. John
Colby, Mrs. Fred
Davison, Mrs. B. H., Port Arthur.
Duren, Mrs. Norman
East, Mrs. H. H.
Eisenstadt, Mrs. H. B.
Engledow, Mrs. R. H.
English, Mrs. Dudley
Ferguson, Mrs. E. C.
Futitta, Mrs. J. J.
Fett, Mrs. Benny, Port Arthur.
Granata, Mrs. S. V.
Hagar, Mrs. D. C.
Harlan, Mrs. H. D.
Harper, Mrs. J. Y., Port Arthur.
Hart, Mrs. Frank
Hart, Mrs. John
Henry, Mrs. C. H.
Hosen, Mrs. Harris, Port Arthur.
Kuhlman, Mrs. Fred, Port Arthur.
Ledbetter, Mrs. L. H.
Lewis, Mrs. Seab
Lindsey, Mrs. Eugene
Lightfoot, Mrs. W. D.
Lombardo, Mrs. R. T.
Lowenstein, Mrs. J. M., Port Arthur.
McRee, Mrs. E. C., Port Arthur.
Makins, Mrs. James.
Mann, Mrs. D. A.
Meyer, Mrs. Paul, Port Arthur.
Middleton, Mrs. W. C.
Mills, Mrs. E. D.
Mixson, Mrs. H. J.
Newton, Mrs. W. A.
Pace, Mrs. B. F., Nederland.
Painton, Mrs. C. E., Port Arthur.
Pecora, Mrs. T. L.
Pentecost, Mrs. C. L.
Petet, Mrs. Paul
Pierson, Mrs. Rogers
Powell, Mrs. L. C.
Pruit, Mrs. L. T.
Raines, Mrs. J. M., Port Arthur.
Serafino, Mrs. L. C.
Simpson, Mrs. R. K.
Smith, Mrs. W. A.
Solis, Mrs. G. R., Port Arthur.
Stoeltje, Mrs. Joe.
Suehs, Mrs. M. E.
Sutton, Mrs. Fred.
Tatum, Mrs. W. E.
Todd, Mrs. Charles.
Torbett, Mrs. J. W., Jr.
Tyndall, Mrs. Tommy.
Walker, Mrs. Taylor.
Wallace, Mrs. W. G.
Ward, Mrs. E. G.
White, Mrs. C. M.
White, Mrs. J. M., Port Arthur.
Williams, Mrs. F. G.
Young, Mrs. I. T., Port Arthur.

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Bellamy, Mrs. R. C., Daisetta.
Bevil, Mrs. Jack, Hull.
Bridge, Mrs. W. H., Anahuac.
Delaney, Mrs. A. L., Liberty.
Fahring, Mrs. George H., Anahuac.
Fahring, Mrs. T. Lloyd, Goose Creek.
Griffin, Mrs. Frank, Liberty.
Jordon, Mrs. B. L., Daisetta.
Richter, Mrs. E. R., Dayton.
Shearer, Mrs. A. R., Mont Belvieu.
Sykes, Mrs. E. W., Anahuac.
Tadlock, Mrs. J. T., Dayton.

NACOGDOCHES COUNTY AUXILIARY*

Barham, Mrs. G. S., 644 North St.
Beall, Mrs. J. F., Beall St.
Blackwell, Mrs. T. J., 209 North St.
Campbell Mrs. G. P., 726 North St.
McKinney, Mrs. E. P., 138 Bailey.
Middlebrook, Mrs. G. F., 805 North St.
Nelson, Mrs. A. L., 721 North St.
Neuville, Mrs. C. F., 1002 Requet St.
Payne, Mrs. C. M., Hayward St.
Pennington, Mrs. T. J., 844 North St.
Smith, Mrs. Clarence, 900 Mound St.
Tucker, Mrs. F. H., 1610 Pecan St.
Tucker, Mrs. F. R., S. Fredonia St.
Tucker, Mrs. Henry, North Heights Addition.
Tucker, Mrs. S. B., 1027 Mound St.

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†Address is Lufkin unless otherwise stated.
‡Address is Beaumont unless otherwise stated.

*Address is Nacogdoches unless otherwise stated.

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Hawkins, Mrs. E. W., 9 Sunset Circle B.
Pearce, Mrs. Wynne.
Peters, Mrs. Leo J., 1212 17th St.
Phillips, Mrs. C. E., 403 2nd St.
Schofield, Mrs. E. C., 1002 Ave. A.
Seastrunk, Mrs. O. C., 1102 Orange.
Shaddock, Mrs. C. B., 202 Knox.
Smith, Mrs. J. V., 405 Schley.
Swickard, Mrs. George Y., 310 Border.
Woolley, Mrs. T. O., 511 7th St.

MEMBERS-AT-LARGE, TENTH DISTRICT

Hurst, Mrs. Thomas L., Center.
Oates, Mrs. L. S., Center.

ELEVENTH OR EASTERN DISTRICT

Mrs. George M. Hilliard
Jacksonville
Council Woman

CHEROKEE COUNTY AUXILIARY

Bullion, Mrs. Charles H., Timberlawn Hospital, Dallas.
Burnett, Mrs. E. W., State Hospital, Rusk.
Cobble, Mrs. T. H., Rusk.
Hall, Mrs. R. L., State Hospital, Rusk.
Hilliard, Mrs. George M., Jacksonville.
Johnson, Mrs. J. F., Rusk.
Kuykendall, Mrs. M. J., State Hospital, Rusk.
Lamb, Mrs. M., 631 El Paso St., Jacksonville.
McDonald, Mrs. W. A., Alto.
McDougle, Mrs. J. B., 621 Neches St., Jacksonville.
Scarborough, Mrs. James S., State Hospital, Rusk.
Simms, Mrs. F. D., State Hospital, Rusk.
Sory, Mrs. W. H., 534 East Rusk St., Jacksonville.
Travis, Mrs. J. M., 531 S. Ragsdale St., Jacksonville.
Travis Mrs. John, 635 Nacogdoches St., Jacksonville.
Travis, Mrs. L. L., 616 El Paso St., Jacksonville.
Travis, Mrs. R. T., 637 San Antonio St., Jacksonville.
Whiteside, Mrs. W. A., State Hospital, Rusk.

HENDERSON COUNTY AUXILIARY†

Baugh, Mrs. J. F., Chandler.
Black, Mrs. W. T., 409 E. Corsicana.
Cockerell, Mrs. L. L., 309 W. Corsicana.
Easterling, Mrs. A. H., 611 E Tyler.
Geddie, Mrs. N. D., 704 S. Palestine.
Henderson, Mrs. R. E., 506 E. College.
Hodge, Mrs. R. H., 710 E. Tyler.
Nash, Mrs. C. H., Jr., W. Corsicana.
Nash, Mrs. C. H., Sr., Wofford Ave.
Price, Mrs. D., 615 E. Corsicana.
Wallace, Mrs. B. C., 207 S. Palestine.
Webster, Mrs. J. K., 806 E. Corsicana.
Weekley, Mrs. C. M., 409 E. Corsicana.

SMITH COUNTY AUXILIARY‡

Bailey, Mrs. W. M., 405 Mockingbird Lane.
Bell, Mrs. G. G., 626 S. Bois d'Arc.
Bradford, Mrs. S. W., 2015 S. College.
Brown, Mrs. Glynne, 223 E. 2nd St.
Brown, Mrs. Irving, 1221 S. Chilton.
Bryant, Mrs. W. Howard, 832 S. College.
Caldwell, Mrs. E. H., 421 S. Bonner.
Clawater, Mrs. E. W., 1517 S. Chilton.
Faust, Mrs. J. J., 305 E. 2nd St.
Jarmon, Mrs. Thomas M., Old Bullard Rd.
McDonald, Mrs. C. C., Highland Park.
Marshall, Mrs. R. L., 905 Mockingbird Lane.
Moore, Mrs. M. H., 722½ S. Bois d'Arc.
Neill, Mrs. L. T., 224 Rowland Dr.
Page, Mrs. Roy L., 1900 S. College.
Pope, Mrs. Irvin, Jr., 423 Vine.
Rhine, Mrs. Leland, 2016 Jarrell.
Rice, Mrs. E. D., 925 S. Chilton.
Ross, Mrs. William, 526 S. Bonner.
Sehested, Mrs. H. C., Troup Highway.
Shirley, Mrs. Clayton, 2418 Old Bullard Rd.
Thompson, Mrs. Orion, 318 W. 3rd.
Willingham, Mrs. C. E., 319 W. 2nd.

*Address is Orange unless otherwise stated.
†Address is Athens unless otherwise stated.
‡Address is Tyler unless otherwise stated.

Windham, Mrs. L. B., 600 W. Rusk.
Woldert, Mrs. Albert, 603 W. Woldert.
Young, Mrs. C. B., 929 S. Confederate.

TWELFTH OR CENTRAL DISTRICT

Mrs. G. V. Brindley
Temple
Council Woman

BELL COUNTY AUXILIARY*

Alsup, Mrs. A. H., 1216 N. 3rd St.
Anderson, Mrs. H. B., 613 W. Lamar.
Bassel, Mrs. Paul M., Belton.
Bauman, Mrs. J. E., 1109 S. 5th.
Blanton, Mrs. Bassel, Belton.
Bradfield, Mrs. E. O., 905 N. 4th.
Brindley, Mrs. G. V., 600 W. Garfield.
Bunkley, Mrs. T. F., 1117 N. 9th.
Burow, Mrs. F. P., Killeen.
Chernosky, Mrs. W. A., 707 N. 3rd.
Curtis, Mrs. R. C., 1315 N. 7th.
Curtis, Mrs. Raleigh, 1919 N. 7th.
Ellis, Mrs. I. D., Troy.
Flett, Mrs. R. M., 1116 N. 9th.
Fowler, Mrs. Joe, Killeen.
Gillespie, Mrs. Charles, 1612 W. Ave. H.
Gober, Mrs. O. B., 404 N. 9th.
Greenwood, Mrs. Joe, 815 N. 9th.
Harlan, Mrs. R. K., 1207 N. 3rd.
Howell, Mrs. F. W., 1307 N. 5th.
Jenkins, Mrs. J. G., Moffatt Rd.
Longmire, Mrs. V. M., 1309 N. 9th.
McCelvey, Mrs. J. S., 804 N. 11th.
Maxwell, Mrs. W. J., 1016 N. 9th.
Moon, Mrs. A. E., 716 N. 13th.
Moreton, Mrs. R. D., 310 N. 1st.
Phillips, Mrs. Charles, 606 N. 9th.
Pittman, Mrs. J. W., Belton.
Pollok, Mrs. L. W., 618 N. 13th.
Powell, Mrs. W. N., 1219 N. 9th.
Ramey, Mrs. P. M., 1714 N. 7th.
Robinson, Mrs. J. E., Waco Highway.
Rodarte, Mrs. J. G., 1011 N. 13th.
Seedorf, Mrs. E. E., 1205 N. 15th.
Sewell, Mrs. H. W., Belton.
Sewell, Mrs. J. G., Belton.
Sherwood, Mrs. M. W., 605 N. 9th.
Shibler, Mrs. S. W., N. 3rd.
Simmon, Mrs. V. J., 814 N. 6th.
Simpson, Mrs. C. M., 1312 N. 7th.
Smith, Mrs. R. M., 1409 N. 4th.
Speed, Mrs. Terrell, 602 N. 3rd.
Stevenson, Mrs. C. A., 1107 N. 4th.
Stuart, Mrs. L. D., 1210 N. Main.
Talley, Mrs. L. R., 1203 N. 3rd.
Veirs, Mrs. E. R., 1520 N. 5th.
Wiedeman, Mrs. A. E., 1111 N. 2nd.
Winston, Mrs. J. R., 304 W. French.
Wolf. Mrs. A. F., 308 N. Main.
Woodson, Mrs. Burbank, 1815 N. 7th.
Woodson, Mrs. Palmer, 605 W. Nugent.

BRAZOS-ROBERTSON COUNTIES AUXILIARY

Andres, Mrs. D. W., College Station.
Boguskie, Mrs. W. M., Hearne.
Cline, Mrs. W. B., Woodville.
Cummings, Mrs. H. W., Hearne.
Grant, Mrs. R. B., Jr., Bryan.
Holt, Mrs. E. E., College Station.
Marsh, Mrs. J. E., College Station.
Perry, Mrs. J. S., Bryan.
Richardson, Mrs. S. C., Bryan.
Searcy, Mrs. T. A., Hearne.
Smith, Mrs. J. A., Hearne.
Walton, Mrs. T. T., Bryan.
Wilkerson, Mrs. L. O., Bryan.
Woodard, Mrs. P. A., College Station.

FALLS COUNTY AUXILIARY†

Barnett, Mrs. J. B., 303 Agnes.
Barnett, Mrs. J. H., 306 Agnes.
Buie, Mrs. N. D., 407 Capps.
Carter, Mrs. H. G., 403 Capps.
Collier, Mrs. J. I., 717 Walker.
Cornwall, Mrs. C. H., 407 Capps.
Davison, Mrs. M. A., 332 Agnes.
Garrett, Mrs. H. S., 317 Houghton.
Glass, Mrs. T. G., 127 Watson.
Hampshire, Mrs. G. H., 125 Winter.
Hutchings, Mrs. A. M., 549 Capps.
Hutchings, Mrs. E. P., 131 Maryland.
McKinley, Mrs. W. F., 111 Potomac.
Smith, Mrs. H. O., 200 Southland.
Smith, Mrs. W. S., Jr., 337 Agnes.
Swetland, Mrs. D. R., 129 Southland.
Torbett, Mrs. J. W., 302 Houghton.
Von Tobel, Mrs. A. E., 108 Watson.

*Address is Temple unless otherwise stated.
†Address is Marlin unless otherwise stated.

JOHNSON COUNTY AUXILIARY*

Dennis, Mrs. M., 103 Sunset Dr.
Doughtie, Mrs. Jack, 611 Forest Ave.
Fine, Mrs. Eldon, 732 N. Main.
Jowell, Mrs. C. D., Grandview Highway.
Knox, Mrs. M. T., 201 Belview Dr.
Little, Mrs. J. G., 606 W. Chambers.
Pickens, Mrs. J. W., 302 Forest.
Smyth, Mrs. Jack, 216 Forest.
Turner, Mrs. B. H., 201 Featherston.
Whitehouse, Mrs. Gladys, 401 Chambers.
Yater, Mrs. Tolbert, 109 Sunset.

McLENNAN COUNTY AUXILIARY†

Alexander, Mrs. Boyd, 1028 N. 18th.
Alexander, Mrs. R. B., 3725 Castle.
Ainsworth, Mrs. H. T., 3000 Cumberland.
Ainsworth, Mrs. M. B., 436 Rice.
Anspach, Mrs. H. M., 2711 Maple.
Baker, Mrs. M. D., 2806 Washington.
Brooks, Mrs. C. H., 2300 Bosque.
Bullard, Mrs. Roy E., 2602 Fant.
Connally, Mrs. H. F., 2223 Colcord.
Dudgeon, Mrs. H. R., 2200 Gorman.
Garnett, Mrs. J. M., 2221 Parrott.
Hanks, Mrs. R. J., 3222 Cumberland.
Howard, Mrs. Stanley, 1809 S. 8th.
Johnson, Mrs. Ernest, Baker Lane.
Kirby, Mrs. F. F., 2801 Sanger.
Magid, Mrs. Moreton, 2829 Windsor.
Murphey, Mrs. Paul, 3100 Maple.
Power, Mrs. Paul, Orchard Lane.
Reese, Mrs. Clarence, 2400 Fant.
Reese, Mrs. Walter L. (Assoc.), 1616 N. 5th.
Spencer, Mrs. Shelby, 419 N. 22nd.
Simpson, Mrs. Neil, Hardin Apts.
Trice, Mrs. W. G., 414 N. 22nd.
Warren, Mrs. Dan, 1322 Washington.
Witte, Mrs. W. S., Palm Courts.
Woolsey, Mrs. W. J., Lake Waco.

MEMBERS-AT-LARGE, TWELFTH DISTRICT

Goodall, Mrs. C. L., Clifton.
Goodall, Mrs. Van Doren, Clifton.
Witcher, Mrs. S. L., Clifton.

THIRTEENTH OR NORTHWESTERN DISTRICT

Mrs. A. W. Brazda
Ranger
Council Woman

BAYLOR-KNOX-HASKELL COUNTIES AUXILIARY

Eiland, Mrs. D. C., Munday.

TARRANT COUNTY AUXILIARY‡

Allison, Mrs. Wilmer L., 4603 Norma St.
Anderson, Mrs. James V., 1308 Hemphill St.
Anderson, Mrs. R. B., 4109 El Campo St.
Andujar, Mrs. John J., 2951 Benbrook Blvd.
Anthony, Mrs. Ernest E., Jr., 1210 W. Jessamine.
Antweil, Mrs. A., 1919 Forest Park Blvd.
Armstrong, Mrs. W. Frank, 2432 Medford Court E.
Baker, Mrs. R. G., 5824 Medford Court E.
Ball, Mrs. Bert C., 6128 Highland.
Ball, Mrs. Charles E., 4208 Lone Oak Dr.
Barcus, Mrs. James R., 1713 Ashland.
Barcus, Mrs. W. S., 2020 Hillcrest.
Beall, Mrs. Frank C., 1420 N. Ballinger.
Beall, Mrs. K. H., 1600 Sunset Terrace.
Beavers, Mrs. G. Herbert, 46 Valley Ridge Rd.
Bennett, Mrs. Jerrell, 3501 Bellaire Dr. S.
Bond, Mrs. Tom B., 815 Medical Arts Bldg.
Brasher, Mrs. Ray, 112 Williamsburg Lane.
Brewster, Mrs. Burke, 2562 Boyd.
Brown, Mrs. J. Hyal, 2409 Medford Court W.
Brown, Mrs. W. Porter, Rt. 6, Box 472, Denton Rd.
Campbell, Mrs. J. F., 2703 Scott.
Carpenter, Mrs. Nathan C., 3612 Potomac.
Cassidy, Mrs. John M., 3232 University Dr.
Chambers, Mrs. James O., 3715 Lenox.
Cheatham, Mrs. T. H., 2124 Park Pl.
Chorn. Mrs. Maurice H., 2420 Wabash.
Clayton, Mrs. Charles F., 5930 White Settlement Rd.

*Address is Cleburne unless otherwise stated.
†Address is Waco unless otherwise stated.
‡Address is Fort Worth Unless otherwise stated.

Covert, Mrs. J. D., 1508 Hemphill.
Crabb, Mrs. M. H., 3613 Park Hill Dr.
Cross, Mrs. Thomas J., 2424 Lofton Terrace.
Daly, Mrs. Jack, 2200 Huntington Lane.
Daly, Mrs. I. J. (Assoc.), 3900 Lake Worth Dr.
Davis, Mrs. Edwin, 1320 Washington.
Day, Mrs. Giles W., 3932 Modlin.
Deaton, Mrs. Hobart O., 1221 Clara St.
Ditto, Mrs. H. Howard, 108 N. Bailey.
Doss, Mrs. Keller, 2701 Benbrook Blvd.
Douglass, Mrs. Hal C., 3712 Bellaire Dr. N.
Duringer, Mrs. W. C., 2508 Ryan Pl. Dr.
Emery, Mrs. O. J., 2120 Tremont.
Enloe, Mrs. George R., 607 Rivercrest Dr.
Francis, Mrs. Fred W., 2614 Kensington Dr.
Garrett, Mrs. C. C., 4800 Byers.
Givens, Mrs. J. M., 127 W. Broadway.
Godley, Mrs. L. O., 2129 Park Pl.
Goldberg, Mrs. A. L., 1937 Forest Park Blvd.
Goodman, Mrs. T. L., 1933 Forest Park. Blvd.
Gough, Mrs. R. H., 2211 Pembroke Dr.
Griffith, Mrs. M. A., 2110 Pembroke Dr.
Grogan, Mrs. O. R., 3200 Avondale.
Grogan, Mrs. R. L., 3009 Simondale.
Guerra, Mrs. R. Lopez, 1509 Ellis.
Hall, Mrs. E. P., Sr., 2233 Hemphill.
Hallmark, Mrs. J. A., 2710 Simondale Dr.
Harper, Mrs. Henry, 2741 5th Ave.
Harris, Mrs. Earl, 2005 Warner Rd.
Hawkins, Mrs. C. P., 3700 Tulsa Way.
Hayes, Mrs. C. F., 1609 Harrington.
Hiett, Mrs. Carey, 1424 Virginia Pl.
Higgins, Mrs. W. P., Jr., 3206 Sondra.
Hightower, Mrs. Lovick P., 800 Virginia Pl.
Hook, Mrs. James H., 3917 Potomac.
Horn, Mrs. Will S., 2217 Winton Terrace.
Howard, Mrs. E. L., Rt. 1, Box 110, Birdville.
Howard, Mrs. Rex, 3125 Wabash.
Huffman, Mrs. A. M., 3029 Lipscomb.
Hulsey, Mrs. Sim, 2414 Ward Parkway.
Hyde, Mrs. X. R., Riverlake Dr.
Jackson, Mrs. A. E., Lake Worth.
Jackson, Mrs. H. T., 416 Crestwood Dr.
Jagoda, Mrs. Samuel, 2512 5th Ave.
Jenkins, Mrs. W. N., 2609 Greene.
Kibbie, Mrs. Horace K., 2417 Medford Court E.
Kibbie, Mrs. Kent V., 715 W. Leuda.
Kingsbury, Mrs. H. B., 2041 Windsor Pl.
Kramer, Mrs. J. T., Jr., 1905 N. Riverside Dr.
Lace, Mrs. Ted, 3721 W. Cliff Rd. N.
Lackey, Mrs. W. C., 2300 Medford Court E.
Lacy. Mrs. George W., 3200 Mt. Vernon.
Ladd, Mrs. A. D., 1109 S. Henderson.
Lange, Mrs. A. A., 2600 Ryan Pl. Dr.
Lauderdale, Mrs. T. L., 2212 Hawthorne.
Lawson, Mrs. J. Mack, 3724 Bellaire Dr. N.
Littlepage, Mrs. H. B., 814 W. Terrell.
Lorimer, Mrs. W. S., 2240 Winton Terrace W.
Lucy, Mrs. Louis, 129 Williamsburg Lane.
Lyle, Mrs. Judge M., 2421 Stadium Dr.
McKean, Mrs. R. W., Rt. 7, Box 299.
McKee, Mrs. Frank, 2300 Avalon Court.
McVeigh, Mrs. J. F., 4800 Crestline Rd.
Matheson, Mrs. D. N., 2500 Cockrell.
Mulkey, Mrs. Y. J., 2309 Harrison.
Munter, Mrs. Craig, 3811 Potomac.
Murchison, Mrs. S. J. R., 3205 Stadium Dr.
Neighbors, Mrs. DeWitt, 2221 Edwin.
O'Bannon, Mrs. R. P., 2135 Warner Rd.
Ott, Mrs. William O., 1019 W. Terrell.
Phillips, Mrs. W. G., 3115 Race St.
Price, Mrs. Sidney A., 957 E. Mulkey.
Pumphrey, Mrs. A. B., White Settlement Rd.
Rathgeber, Mrs. Van D., 2320 Mistletoe Blvd.
Renshaw, Mrs. H. S., 2913 Alton Rd.
Richardson, Mrs. J. J., 2404 Medford Court E.
Roberts, Mrs. A. L., 1818 8th Ave.
Robertson, Mrs. J. A. (Assoc.), 3004 Ryan Ave.
Rumph, Mrs. D. M., 1521 Grande.
Rumph, Mrs. Mal, 1940 Forest Park Blvd.
Rumph, Mrs. T. G., 2101 Pembrook Dr.
Schenck, Mrs. C. P., 3117 Stadium Dr.
Schoolfield, Mrs. E. C., 1501 W. Myrtle.
Schoonover, Mrs. Frank S., 600 8th Ave.
Schwarz, Mrs. Edwin G., 2420 Shirley.
Scroggie, Mrs. Val D., 3736 Country Club Circle.
Sewell, Mrs. Robert, 6105 Locke.
Shaw, Mrs. E. L., 1908 Ashland.
Sheddon, Mrs. Frank G., 1313 Sinclair Bldg.
Shelley, Mrs. Harold J., 4071 Modlin.
Shilling, Mrs. H. C., 2205 N. Houston.
Snyder, Mrs. F. L., 304 Virginia Pl.
Spivey, Mrs. J. L., 2239 W. Magnolia.
Steger, Mrs. J. H., 3100 Bellaire Dr.
Stout, Mrs. Sidney, 3632 Bellaire Dr. N.
Swift, Mrs. W. B., 2817 Alton Rd.
Tatum, Mrs. W. C., 1828 Hillcrest.
Taylor, Mrs. Holman, 2025 Huntington Lane.
Teague, Mrs. William H., 2017 Maple Leaf.
Terrell, Dr. Blanche, 2621 Waits.
Terrell, Mrs. C. E. (Assoc.), 2618 Waits.
Terrell, Mrs. T. C., 2401 Stadium Dr.
Thomas, Mrs. H. P., 3710 Camp Bowie.
Thomason, Mrs. T. H., 4451 Crestline Rd.
Thompson, Mrs. W. R., 2306 6th Ave.
Tom, Mrs. J. C., Jr., 1503 W. Myrtle.
Tottenham, Mrs. John W., Sr., 1204 N. Riverside Dr.
Touzel, Mrs. C. S. E., 1326 Summit.
Trigg, Mrs. Henry B., 68 Westover Terrace.
Trigg, Mrs. Ross, 5600 White Settlement Rd.
Van Zandt, Mrs. I. L., 3815 Lenox.
Walker, Mrs. Webb, 2420 College.
Webb, Mrs. William S., 1209 Thomas Pl.
West, Mrs. Walter B., 3015 Alton Rd.
Wier, Mrs. E. M., 3708 Country Club Circle.
Wiggins, Mrs. John A., Jr., 209 Williamsburg Lane.
Wise, Mrs. Joe R., 3008 Greene.
Withers, Mrs. I. A., 1201 8th Ave.
Woodward, Mrs. C. S., Arlington.
Wright, Mrs. Walker, 3900 Lake Worth Dr.

INACTIVE MEMBERS (SERVICE)

Bailey, Mrs. N. R.
Barker, Mrs. Bob.
Borough, Mrs. L. D.
Chorn, Mrs. E. H.
Church, Mrs. John M.
Cochran, Mrs. J. R.
Davis, Mrs. Haywood.
Eschenbrenner, Mrs. J. W., Jr.
Farrington, Mrs. N. C.
Fershtand, Mrs. J. B.
Funk, Mrs. Theron.
Garnett, Mrs. J. W.
Hall, Mrs. E. P., Jr.
Halpin, Mrs. Frank W.
Hewatt, Mrs. J. W.
Horn, Mrs. J. M.
Isaacks, Mrs. Hub.
McCollum, Mrs. Charles H., Jr.
McKenzie, Mrs. Walter.
Mitchell, Mrs. Gatlin.
Morris, Mrs. A. J.
Siddons, Mrs. George Y.
Stow, Mrs. R. C.
Summer, Mrs. W. W.
Tottenham, Mrs. J. W., Jr.
Terrell, Mrs. Charles J.
Terrell, Mrs. C. O., Jr.
Wooten, Mrs. J. H.
Wooten, Mrs. R. W.

TAYLOR-JONES COUNTIES AUXILIARY*

Adamson, Mrs. W. B., 2425 Swenson.
†Alexander, Mrs. J. M., 602 Victoria.
Bass, Mrs. T. B., 1711 Holbron.
Bailey, Mrs. S. W., 641 Hickory.
Barnett, Mrs. W. H., 3498 Ward.
Bridges, Mrs. J. B., 1350 Meander.
Cash, Mrs. W. A. V., 901 Albany.
Crow, Mrs. Jack A., 1809 S. 14th.
Clark, Mrs. J. Frank, (Member-at-large) Georgetown.
Daly, Mrs. J. M., 1026 Marshall.
Estes, Mrs. J. M., 1934 Hickory.
Estes, Mrs. J. M., Jr., 641 Hickory.
Grubbs, Mrs. L. F., 623 Amarillo.
Gibson, Mrs. J. P., 1526 N. 19th.
Hedrick, Mrs. T. Wade, 1310 Sylvan Dr.
Hodges, Mrs. Frank C., 102 Oldham.
Hollis, Mrs. Lonnie W., Jr., 1865 N. 7th.
Hollis, Mrs. Scott W., 1202 Sayles Blvd.
Johnson, Mrs. L. F., 1399 Austin.
Kirkpatrick, Mrs. R. B., 918 Palm.
Latham, Mrs. J. B., 1925 N. 5th.
Leggett, Mrs. C. B., San Angelo Highway.

*Address is Abilene unless otherwise stated.
†Deceased.

Little, Mrs. O. W., 1330 N. 2nd.
Mathews, Mrs. W. J., 1326 Highland.
Magee, Mrs. J. D., Jr., 633 Sayles Blvd.
Middleton, Mrs. E. E., Ann Arbor, Mich.
Middleton, Mrs. E. R., 842 Sayles Blvd.
McDonald, Mrs. Donald, 51 Agnola Crestwood, Tuckahoe, N. Y.
McFadden, Mrs. C. A., 1039 Sayles Blvd.
Pattillo, Mrs. Guy, 1018 Sayles Blvd.
Pickard, Mrs. L. J., 1326 Meander.
Pritchard, Mrs. C. L., 2042 S. 8th.
Ramsey, Mrs. H. H. (Assoc.), 430 Victoria.
Ramsey, Mrs. W. V., 1682 Hickory.
Sadler, Mrs. W. T., Merkel.
Seale, Mrs. Hubert, 735 Sayles Blvd.
Sellers, Mrs. Erle D., 1301 Elmwood.
Shytles, Mrs. Grady, 941 Ross.
†Snow, Mrs. William R., 702 Sayles Blvd.
Thurman, Mrs. George D., 1141 N. 21st.
Tull, Mrs. Raymond, 1658 N. 21st.
Whiting, Mrs. E. T., Washington, D. C.

WICHITA COUNTY AUXILIARY*

Adams, Mrs. W. W., 2024 Downing.
Arrington, Mrs. J. H., 2114 Hayes.
Atkinson, Mrs. Curtis, 1302 Polk.
Caskey, Mrs. M. W., 2410 Speedway.
Clark, Mrs. Gordon, Iowa Park.
Collard, Mrs. T. R., 2414 9th.
Collins, Mrs. Paul, 1815 McGregor.
Cox, Mrs. A. E., 1815 Ardath.
Crump, Mrs. W. E., 1673 Dayton.
Daily, Mrs. R. L., 1819 McGregor.
Dorbandt, Mrs. B. W., 2201 Avondale.
Egdorf, Mrs. O. C., 1605 13th.
Glover, Mrs. M. H., 1712 11th.
Guest, Mrs. J. C. A., 1800 11th.
Hall, Mrs. J. D., 1723 Elizabeth.
Hargrave, Mrs. R. L., 1824 Huff.
Hartsook, Mrs. C. R., 2715 9th.
Holland, Mrs. L. B., 1655 Pearl.
Johnson, Mrs. J. A., 1711 Victory.
Kanatser, Mrs. J. E., 2103 Miramar.
Kiel, Mrs. O. B., 2104 Miramar.
Kimbrough, Mrs. O. T., 1920 Victory.
Knox, Mrs. R. T., William Mary Hotel.
Leach, Mrs. A. T., 1503 Hayes.
Ledbetter, Mrs. Harry, 1905 Victory.
Ledford, Mrs. H. P., 3212 Beech.
Lee, Mrs. A. B., 1718 Huff.
Little, Mrs. J. A., 2107 Berkley.
Lowry, Mrs. W. P., 300 Morningside.
Lynch, Mrs. T. C., 5 Lincoln.
Manar, Mrs. R. W., 1820 Wilson.
Mangum, Mrs. C. E., 2901 Taft.
Monroe, Mrs. C. W., Electra.
Nail, Mrs. J. B., 2023 Berkley.
Nelson, Mrs. R. L., 2204 Avondale.
Parnell, Mrs. L. D., 1508 Tilden.
Pattillo, Mrs. A. D., Jr., State Hospital.
Prichard, Mrs. H. D., 3715 Kessler.
Reagan, Mrs. J. R., 2400 Ellingham.
Reser, Mrs. W. A., 2005 Bluff.
Rundell, Mrs. W. K., 1815 Collins.
Russell, Mrs. L. C., Burkburnett.
Seay, Mrs. J. A., Iowa Park Rd.
Singleton, Mrs. G. T., 2207 Avondale.
Smith, Mrs. M. Z., 2909 Ave. L.
Smith, Mrs. P. K., 2110 Wenonah.
Sullivan, Mrs. H. C., Burkburnett.
Wilson, Mrs. O. W., 1006 Brook.

MEMBERS-AT-LARGE, THIRTEENTH DISTRICT

Brazda, Mrs. A. W., Ranger.
Brown, Mrs. L. C., Eastland.
Jackson, Mrs. C. L., Ranger.
Kuykendall, Mrs. P. M., Ranger.
Townsend, Mrs. E. Roy, Eastland.

FOURTEENTH OR NORTHERN DISTRICT

Mrs. O. W. Robinson

Paris

Council Woman

COOKE COUNTY AUXILIARY‡

Atchison, Mrs. J. W., 515 Lindsey.
Hawk, Mrs. H. P., 1115 E. Scott.
Myrick, Mrs. Thomas, Muenster.
Thayer, Mrs. C. B., 1014 S. Denton.
Thomas, Mrs. I. L., 628 Lindsey.
Whiddon, Mrs. R. C., 1112 Lindsey.
Yarbrough, Mrs. S. M., 312 S. Grande.

*Address is Wichita Falls unless otherwise stated.
‡Address is Gainesville unless otherwise stated.
†Deceased.

DALLAS COUNTY AUXILIARY*

Addison. Mrs. R. P., 5429 Gaston.
Alessandra, Mrs. S. A., 611 Opera.
Alexander, Mrs. Jo C., Stoneleigh Court Hotel.
Alexander, Mrs. Lee J., 4329 Greenbrier.
Allday, Mrs. L. E., 4224 Stanhope.
Allen, Mrs. Burton W., 5647 Ridgedale.
Allison, Mrs. Wilfred J., 6948 Lakeshore Drive.
Altick, Mrs. Frank, 5914 Goliad.
Altman, Mrs. William A., 1528 Oak Knoll.
Andrew, Mrs. Warren, 4211 Swiss.
Arnoff, Mrs. B. L., Melrose Hotel.
Arnold, Mrs. L. E., 3644 Greenbrier.
Aronson, Mrs. Hattie, Maple Terrace Hotel.
Ashby, Mrs. John E., 3429 Cornell.
Aten, Mrs. Eugene L., 4401 Westside.
Ault, Mrs. C. A., Jr. (Service).
Austin, Mrs. Dale, 4417 Atoka.
Austin, Mrs. Frank H., 4504 Arcady.
Bagwell, Mrs. John S., 3236 Purdue.
Baird, Mrs. Sidney S., 3549 Southwestern
Baird, Mrs. W. Leroy, 2508 Oak Lawn.
Baldwin, Mrs. Alvin, Jr., 4502 University Blvd.
Barnes, Mrs. Dorsey K., 5419 Farquhar Lane.
Barnett, Mrs. William E., 3520 Fairmount.
Barr, Mrs. Tom, 4683 Belclaire.
Barta, Mrs. C. K. (Service).
Barton, Mrs. Robert M., 4513 Beverly Dr.
Basom, Mrs. W. Compere, 809 N. Beckley.
Beall, Mrs. John R., Beverly Dr.
Beaver, Mrs. N. B., 4329 Fairfax.
Beckering, Mrs. H. H., 4321 Beverly Dr.
Bell, Mrs. Marvin D., 6347 Tremont.
Berger, Mrs. B. J., 3916 Stonebridge Dr.
Black, Mrs. J. H., 3624 Princeton.
Bland, Mrs. Leonard F., 4621 Munger.
Block, Mrs. Harold M., 4312 Fairfax.
Bourland, Mrs. J. W., Jr., 4438 Arcady.
Bourland, Mrs. John B., 3409 Beverly Dr.
Bradford, Mrs. William H., 4679 Westside Dr.
Brannin, Mrs. Dan, 4103 Averill Way.
Brannin, Mrs. Edward B., 7708 S. Haskell.
Brau, Mrs. Gilmore, 1117 N. Washington.
Brooks, Mrs. E. J., 1205 N. Edgefield.
Brown, Mrs. Frank, 4401 Edlen.
Brown, Mrs. S. Roland (Service).
Browne, Mrs. W. C., 705 N. Marsalis.
Brooksaler, Mrs. Fred, 4332 Grassmere Lane.
Bruton, Mrs. Emmet B., 5218 Vickery Blvd.
Buchanan, Mrs. J. Forest, 4001 Druid Lane.
Buehler, Mrs. Martin S., 4811 Bluff View.
Bumpass, Mrs. S. R., 6918 Vivian.
Burgess, Mrs. George A. (Service).
Butte, Mrs. Felix L., 3700 Maplewood.
Bywaters, Mrs. T. W., Falls Rd.
Caillet, Mrs. O. Rene, 5002 W. Lovers Lane.
Cairns, Mrs. Buell, 2806 Hedgerow.
Calhoun, Dr. Nina Fay, Stoneleigh Court Hotel.
Carlson, Mrs. G. D., 9408 Inwood.
Carman, Mrs. H. Frank, 6228 Preston Rd.
Carrell, Mrs. Brandon, 4429 Belclaire.
Carrell, Mrs. W. B., 2317 Welborn.
Carswell, Mrs. W. E., 6722 Lakeshore Dr.
Carter, Mrs. C. B., 4500 Normandy.
Carter, Mrs. Charles F., 4519 Rheims Pl.
Carter, Mrs. Earl L., 6660 Lakeshore Dr.
Cary, Mrs. Edward H., 4712 Lakeside Dr.
Chapman, Mrs. John S., 3828 Purdue.
Cheavens, Mrs. Tom H., 708 N. Glasgow Drive.
Cinnamon, Mrs. Alfred M., 6938 Casa Loma.
Clark, Mrs. Harold G., 4742 Mockingbird Lane.
Coble, Mrs. J. M., 2504 Maple.
Cochran, Mrs. H. Walton, 3308 St. John's Dr.
Collier, Mrs. Gates, 2219 N. Fitzhugh.
Copeland, Mrs. F. R., 3506 Springbrook.
Cowart, Mrs. Robert W., 4313 Worth.
Cox, Mrs. Eli R., 5744 Gaston.
Crutcher, Mrs. Howard K., 1606 Junior Dr.
Daniel, Mrs. Robert H., 3313 Dartmouth.
Daniel, Dr. Ruby K., 4212 Loma Alto.
Dathe, Mrs. Richard, 5514 Vanderbilt.
Davidson, Mrs. G. A., 1025 Cordova.
Davis, Mrs. David B., 1832 South Blvd.
Dawson, Mrs. J. L., 9825 Northwest Highway.
Dean, Mrs. John H., 5001 Northwest Highway.

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Deatherage, Mrs. William, 4517 Reiger.
Decherd, Mrs. Henry B., 3717 Hall.
Denton, Mrs. Guy T., Jr., 2519 Marvin.
D'Errico, Mrs. Albert, Stoneleigh Court Hotel.
Devereaux, Mrs. W. P., 3808 Miramar.
Dickey, Mrs. E. V., 3508 Harvard.
Donald, Mrs. Homer, 1545 W. Colorado Blvd.
Dorman, Mrs. J. H., 3636 Lovers Lane.
Dozier, Mrs. Fred, 4225 Bryn Mawr.
Duckett, Mrs. J. W., 3529 Caruth Blvd.
Duncan, Mrs. Charles N., 3737 Shenandoah.
Dunlap, Mrs. Elbert, 3712 Lemmon.
Dunlap, Mrs. John, 5032 Wenonah Dr.
Dunstan, Mrs. E. M. (Service).
Edwards, Mrs. William L., 2014 Euclid.
Embree, Mrs. John W., 4218 Fairfax.
Evans, Mrs. Edward L. (Service), 906 Cedar Hill.
Evans, Mrs. W. G., 4065 Purdue.
Everhart, Mrs. Merrill, 3610 Fairmount.
Ferguson, Mrs. Doyle W., 1418 S. Montreal.
Fowler, Mrs. W. W., 4530 Munger Ave.
Fox, Mrs. Everett C., 4224 Loma Alto.
Franklin, Mrs. Floyd S., 4675 Edmondson.
Franklow, Mrs. C. D., Adolphus Hotel.
Freedman, Mrs. S. M., Maple Terrace Hotel.
Frew, Mrs. Athol L., Jr., 6605 Robin Rd.
Fry, Mrs. Murdock D., 6445 Lakewood Blvd.
Fuqua, Mrs. W. N., 4221 Versailles.
Gauldin, Mrs. Robert J., 6118 Llano.
Gessner, Mrs. F. E., 7235 Lakewood Blvd.
Gibbons, Mrs. O. W., 4329 Lorraine.
Giles, Mrs. Robert B., 3900 Potomac.
Gill, Mrs. Horace E., 604 Story.
Girard, Mrs. P. M., 4433 Edmondson.
Glass, Mrs. R. J.
Goff, Mrs. G. F., 3817 Maplewood.
Goforth, Mrs. J. L., 6907 Westlake.
Goode, Mrs. John V., 4376 W. Potomac.
Gordon, Mrs. E. S., 511 Brookside Dr.
Gottich, Mrs. Arthur P., 4512 W. Potomac.
Graham, Mrs. James F., 401 N. Oak Cliff Blvd.
Green, Mrs. F. R., 8327 Santa Clara.
Green, Mrs. Tim, 1217 N. Tyler.
Greer, Mrs. B. F., 206 W 10th St.
Griffin, Mrs. B. H., Frost.
Grollman, Mrs. Arthur, 3501 Princeton.
Grow, Mrs. Max (Service).
Guerriero, Mrs. William F., 5321 Farquhar Lane.
Hacker, Mrs. Guy L., 3600 Colgate.
Hackler, Mrs. G. M., 3928 University Blvd.
Hackney, Mrs. U. P., 5703 Vanderbilt.
Haley, Mrs. W. E., 4720 St. John's Dr.
Halpern, Mrs. Salmon R., 4202 Wycliff.
Hampton, Mrs. J. A., 4433 S. Versailles.
Hannah, Mrs. Calvin R., 3921 Potomac.
Harder, Mrs. Ira E., 4931 Park Lane.
Harrington, Mrs. F. T., Samuell Blvd., P. O. Box 1769.
Harrington, Mrs. S. F., 3722 Cragmont.
Harris, Mrs. N. J. (Service).
Harrison, Mrs. Ben F., 3115 Amherst.
Harrison, Mrs. Gaston G., 4308 Arcady.
Harrison, Mrs. Tinsley R., 7048 Turtle Creek.
Harvill, Mrs. T. Haynes (Service).
Hawkins, Mrs. Hubert F., 2100 W. Kessler Parkway.
Hawley, Mrs. J. Leeper, 4429 Amherst.
Henry, Mrs. D. J. (Service), 6447 Kenwood.
Herndon, Mrs. James, 406 S. Winnetka.
Hill, Mrs. J. M., 6752 Avalon.
Hill, Mrs. S. M., 3617 Lexington.
Hilliard, Mrs. George M. (Service).
Hodges, Mrs. J. Shirley, 3516 University.
Hodges, Mrs. Leon, 1520 W. Davis.
Holt, Mrs. J. O. S., 5504 Willis.
Hopkins, Dr. May Agnes, 4517 Highland Dr.
Horn, Mrs. Fred, 3132 Southwestern.
Howard, Mrs. George W., 628 Haynes.
Howard, Mrs. William E., 6616 Gaston.
Hudson, Mrs. Lee, 4312 Overhill Dr.
Jackson, Mrs. M. C., 5848 Oram.
Jackson, Mrs. Reuben W., 4200 DeLoache.
Jackson, Mrs. Rice R., 5639 Gaston.
Jenkins, Mrs. John L., Rt. 7, Forest Lane.
Jenkins, Mrs. Speight, 9101 Preston Rd.
Jones, Mrs. Everett, Stoneleigh Court Hotel.
Jones, Mrs. J. Guy, 6875 Tokalon Dr.
Jones, Mrs. W. D., 5808 Gaston.
Kerr, Mrs. Jack G., 3513 Milton.
Kilgore, Mrs. Donald G., 4324 St. John's Dr.
Kindley, Mrs. George C., 5211 Live Oak.

King, Mrs. Karl B., 3809 Purdue.
Kirksey, Mrs. Tom M., 4521 N. Versailles.
Knowles, Mrs. W. Mood, 6636 Avalon.
Knox, Mrs. Robert, 4348 Livingston.
Kreymer, Mrs. George, 1016 N. Peak.
LaDue, Mrs. Charles N., 3307 Douglas.
Laugenour, Mrs. D. P., 4549 Arcady.
Launey, Mrs. George V., 4627 Fairfax.
Lee, Mrs. Ridings E., 5903 McComas.
Leeper, Mrs. Edward P., 4504 San Carlos.
Lehmann, Mrs. John R., 3921 Potomac.
Levin, Mrs. Paul M., 6318 Westchester Dr.
Levy, Mrs. H. R., 4019 Druid Lane.
Littell, Mrs. George S. (Service)
Lively, Mrs. W. M., Jr., 1247 S. Marsalis.
Loftis, Mrs. Earl L., Wildwood.
Long, Mrs. G. D., 2904 Yale.
Looney, Mrs. W. W., 2223 Barberry.
Lott, Mrs. Mark E., 6214 Gaston.
Love, Mrs. Thomas Stafford, Midway & N. Shore Rds.
McBride, Mrs. Dayton G., 3629 Beverly.
McBride, Mrs. R. B., 6700 Turtle Creek.
McCracken, Mrs. Joseph H., Jr., 4401 Highland Dr.
McFarland, Mrs. Gordon B., 8728 Inwood Rd.
McIver, Mrs. Julius, 3224 Southwestern.
McLaurin, Mrs. Hugh L., Jr., 4801 Seneca Dr.
McLaurin, Mrs. John G., 4710 Munger.
McLeod, Mrs. J. N., 6722 Lakewood.
Maddox, Mrs. W. Gordon, Rt. 5, Box 187-B.
Mahon, Mrs. G. D., Rt. 1, Garland.
Marchman, Mrs. O. M., 5328 Live Oak.
Marshall, Mrs. J. H., 6241 La Vista Dr.
Martin, Mrs. Charles L., Rt. 6, Box 543.
Martin, Mrs. W. E., Gus Thomasson Rd.
Mason, Mrs. Porter K., 3910 Bryn Mawr.
Massey, Mrs. Warren E., 3304 Stanford.
Mathews, Mrs. Paul W., 4327 W. Potomac.
Maxfield, Mrs. J. R., 3601 Milton.
Maxfield, Mrs. J. R., Jr., 4304 Versailles.
Mazer, Mrs. Morton L., 4719 Live Oak.
Mendenhall, Mrs. Elliott, 4221 Belclaire.
Mengert, Mrs. William F., 4505 Southern.
Merrick, Mrs. Ben, 4138 Hawthorne.
Metz, Mrs. Hill, 6811 Hunters Glen. (Service).
Miller, Mrs. Tate, 4127 Hyer.
Milliken, Mrs. S. E., 3925 Maple.
Milliken, Mrs. S. Ramsey, 4918 Swiss.
Mills, Mrs. James T., 2609 Haynes.
Minnett, Mrs. John S., 3300 Hanover.
Montgomery, Mrs. Henry G., 3116 University.
Moody, Mrs. Joe V., 1534 Junior Dr.
Moore, Mrs. H. Leslie, 4204 Beverly Dr.
Moore, Mrs. Ramsay H., 4700 Neola Dr.
Moore, Mrs. Robert L., 4702 Shadywood Lane.
Morris. Mrs. A. Truett, 1430 San Rafael Dr.
Murchison, Mrs. D. R., 4100 Hawthorne.
Nash, Mrs. C. C., 1217 Lausanne.
Neuman, Mrs. Albert, 3829 Hall.
Newsome, Mrs. Asa A., 5906 McComas.
Newton, Dr. Cosette Faust, 4005 Miramar.
Nordenbrock, Mrs. G. J., 4712 Junius.
O'Brien, Mrs. H. A., 4331 Avondale.
O'Brien, Mrs. J. Dennis, 4347 Avondale.
Pace, Mrs. John M., 4849 Montrose.
Park, Mrs. B. E., 1102 N. Edgefield.
Parks, Mrs. Harold (Service).
Paternostro, Mrs. Charles J., 4432 Mockingbird Parkway.
Patterson, Mrs. Casey E., Brookview Rd.
Patterson, Mrs. Cecil O., 4537 Southwestern.
Pence, Mrs. C. P., 5423 Gaston.
Perkins, Mrs. Jack F., 3526 Cedar Springs.
Peyton, Mrs. J. B., 7401 Forest Hill.
Pickard, Mrs. J. M., 2505 Maple.
Pickett, Mrs. Taylor T., Box 81, Garland.
Pierce, Mrs. Franklin A., 6120 Gaston.
Potts, Mrs. W. H., Jr., 4325 Glenwood.
Powell, Mrs. Homer, 7003 Denton Dr. (Service).
Quinn, Mrs. Lester H., 4505 Edmondson.
Rattan, Mrs. Paul M., 4657 Mockingbird Lane.
Reaves, Mrs. L. M., 4553 Bordeaux.
Reddick, Mrs. W. Grady, 4731 Wildwood.
Reed, Mrs. E. P., 4316 Rawlins.
Riddle, Mrs. Pen, 927 N. Tyler.
Riley, Mrs. Joseph G., 3220 Princeton.
Rippy, Mrs. Edwin L., 3622 Fairmount.
Rosenberg, Mrs. M. L. 5718 Anita.
Rosenthal, Mrs. Raoul S., Melrose Hotel.
Ross, Mrs. Edward S., 4220 Shenandoah.
Rouse, Mrs. Milford O., 8326 Gaston.
Rowe, Mrs. J. Forsythe, 1402 Kings Highway.
Rubenstein, Mrs. Bernard, 516 Largent.

Rucker, Mrs. J. C., 3452 Amherst.
Rumpf, Mrs. William H., 3517 Milton.
Sams, Mrs. Lewis C., 834 Salmon Dr.
Scales, Mrs. John G., 328 W. Colorado.
Schaefers, Mrs. J. G., 2720 Purdue.
Schenewerk, Mrs. George A., 3811 DeLoache.
Schmaltz, Mrs. W. F., 5442 Richmond.
Schoch, Mrs. Arthur G., 4109 Averill Way.
Schoolfield, Mrs. Ben L., 5025 Junius.
Schrieber, Mrs. Gus., Jr., 4500 Southern.
Schuett, Mrs. Albert J., 5822 Mercedes.
Scurry, Mrs. Maurice, 5019 Bryan.
Seay, Mrs. Dero E., 3421 Beverly.
Sebastian, Mrs. F. J., 4133 Hawthorne.
Seely, Mrs. M. Stuart, 3911 Gaston.
Selecman, Mrs. Frank, 3609 Rosedale.
Sellers, Mrs. Lyle M., 3412 Southwestern.
Shane, Mrs. J. Howard, 4663 Fairfax.
Shannon, Mrs. Hall, 4230 Fairfax.
Shaw, Mrs. Robert R., 4109 Amherst.
Shelburne, Mrs. Samuel A., 4412 University.
Sheldon, Mrs. Lawrence B., 4531 Fairway.
Shelmire, Mrs. Bedford, 3811 Miramar.
Shoecraft, Mrs. Warren A., 926 Cliffdale.
Short, Mrs. Robert E., 3520 Dartmouth.
Shortal, Mrs. W. W., 7210 Lakewood.
Shuey, Mrs. Charles B., 4436 Southern.
Simpson, Mrs. Charles W., 3517 Beverly.
Singleton, Mrs. J. Dudley, 3716 Amherst.
Slaughter, Mrs. Donald, 4518 Vandelia.
Small, Mrs. Andrew B., 3617 Turtle Creek.
Smith, Mrs. DeWitt, 4126 Normandy.
Smith, Mrs. Edgar, 5650 Gaston.
Smith, Mrs. Ralph C., 4000 Hawthorne.
Smith, Mrs. Richard M., 3659 Maplewood.
Smith, Mrs. Tom E., 1110 N. Oak Cliff Blvd.
Sowers, Mrs. Harry B., 4618 San Jacinto.
Spangler, Mrs. Davis, 4404 Westway.
Sparkman, Mrs. Robert S., 4700 Neola.
Spegal, Dr. Doris.
Spence, Mrs. Harry M., 4533 Lorraine.
Standifer, Mrs. C. H., 1515 Southerland.
Stephenson, Mrs. J. H., 4523 Cedar Springs.
Stephenson, Mrs. W. O., 4005 Hall.
Stone, Mrs. Marvin P., 4417 Southern.
Strother, Mrs. W. K., Jr., 6001 St. Andrews Dr.
Stuart, Mrs. Samuel E., 507 N. Willomet (Service).
Super, Mrs. A. R., 4030 Norway Rd.
Talkington, Mrs. P. C., Samuel Blvd.
Taylor, Mrs. H. Earl, 4218 McFarlin.
Terrell, Mrs. Alex W., 4304 Westway.
Terrill, Mrs. James J., 711 Dumont.
Thomas, Mrs. Maxwell, 435 W. Houston, Sherman.
Thomas, Mrs. Paul J., 4130 Druid Lane.
Thomasson, Mrs. A. R., 4229 Arcady.
Thomasson, Mrs. A. R., Jr., 4229 Arcady.
Thomasson, Mrs. Gus W., Jr., 3411 Prescott.
Thompson, Mrs. B. M.
Thompson, Mrs. L. S., 3620 Princeton.
Thornton, Mrs. C. W., 337 Sunset.
Tittle, Mrs. Guy A., 4201 Belclaire.
Tittle, Mrs. Lloyd C., 3204 Drexel Dr.
Tomkies, Mrs. James S., 6911 Meadow Lake.
Touchstone, Mrs. Jay, 5506 Elden Dr.
Trumbull, Mrs. R. A., Rt. 7.
Tubb, Mrs. Cullen L., 3525 Caruth Blvd.
Underwood, Mrs. George M., 3908 McFarlin.
Usry, Mrs. R. S., 1835 Garrett.
Van Duzen, Mrs. Rex E., 4601 DeLoache.
Veal, Mrs. George T., 6410 Velasco.
Walcott, Mrs. H. G., 5304 Key.
Walker, Mrs. Price M., 4408 Livingston.
Waldman, Mrs. Morris, 403½ Hawthorne.
Wallace, Mrs. Gordon K., 1949 Old Orchard Dr.
Warren, Mrs. Charles H., 4803 Northwest Highway.
Webb, Mrs. Sam, Jr., 3712 Alice.
Wells, Mrs. J. T., 4015 Colonial.
White, Mrs. C. Vincent, 3525 Cedar Springs.
White, Mrs. Edward, 4319 Arcady.
White, Mrs. William T., Stoneleigh Hotel.
Whitten, Mrs. Merritt B., 4335 Lorraine.
Wilkinson, Mrs. Albert, 1021 N. Montclair.
Wilkinson, Mrs. Wallace B., Rt. 1, Box 502.
Williams, Mrs. Paul C., 3844 Turtle Creek.
Williams, Mrs. T. S., 318 Beckleywood Blvd.
Winans, Mrs. Henry M., 3825 Beverly Dr.
Winborn, Mrs. C. D., 5543 Ridgedale.
Winn, Mrs. Robert E. (Service).
Winn, Mrs. Watt W., 3520 Hanover.
Witt, Mrs. Guy F., 6801 Hunters Glen Rd.
Wolfe, Mrs. Joseph, 2927 South Blvd. (Service).
Woodward Mrs. G. T., 1310 Kings Highway.
Woodward, Mrs. T. Leroy, 5711 Vanderbilt.
Woods, Mrs. Ozro T., 3501 Harvard.
Wright, Mrs. Carlton C. (Service).
Wright, Mrs. R. E., 3801 Amherst.
Yancey, Mrs. R. S., 4629 Wenonah Dr.
Young, Mrs. John G., 3514 Rock Creek Dr.
Zuelzer, Mrs. Wilhelm, (Service).

ELLIS COUNTY AUXILIARY

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Campbell, Mrs. W. E., Ennis.
Clark, Mrs. J. L., Ennis.
Clark, Mrs. L. E., Ennis.
Estes, Mrs. T. G., Waxahachie.
Gough, Mrs. E. F., Waxahachie.
Hastings, Mrs. M. E., Waxahachie.
Jenkins, Mrs. J. B., Waxahachie.
Jeter, Mrs. J. R., Ennis.
Jones, Mrs. J. E., Waxahachie.
Simms, Mrs. W. P., Waxahachie.
Sweatt, Mrs. O. P., Waxahachie.
Tenery, Mrs. R. M., Waxahachie.
Tenery, Mrs. W. C., Waxahachie.
Thomas, Mrs. A. L., Ennis.
Watson, Mrs. H. S., Waxahachie.

GRAYSON COUNTY AUXILIARY

Blasingame, Mrs. Doak, 1106 W. Sears, Denison.
Brown, Mrs. H. L., 511 S. Travis, Sherman.
Carraway, Mrs. J. H., 1212 N. Woods, Sherman.
Etter, Mrs. E. F., 1112 N. Woods, Sherman.
Fowler, Mrs. F. F. 1112 W. Walker, Denison.
Freeman, Mrs. Don., 915 Bond, Denison.
Freeman, Mrs. William, 931 Bond, Denison.
Gleckler, Mrs. Arthur, 1102 S. Crockett, Sherman.
Gleckler, Mrs. John, 915 Gandy, Denison.
Greer, Mrs. G. W., Whitesboro.
Hailey, Mrs. E. L., 1105 Bond, Denison.
Henschen, Mrs. G. E., 926 S. Travis, Sherman.
Jamison, Mrs. D. K., 1112 Morton, Denison.
Lee, Mrs. W. A., 1201 Morton, Denison.
Levin, Mrs. S. O., 1430 Gandy, Denison.
Mayes, Mrs. J. A., 1301 Gandy, Denison.
Pierce, Mrs. Paul, 1400 Walker, Denison.
Russell, Mrs. B. A., 826 W. Houston, Sherman.
Sporer, Mrs. Frank, Van Alstyne.
Stout, Mrs. H. I., 811 S. Crockett, Sherman.
Strother, Mrs. C. D., 1418 Preston Dr., Sherman.
Tuck, Mrs. Vernon, 1902 S. Travis, Sherman.
Woodard, Mrs. Max, 1020 Leslie, Sherman.
Williams, Mrs. E. C., Collinsville.

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Connor, Mrs. W. E., Cumby.
Faulk, Mrs. L., 529 S. Davis St.
Hanna, Mrs. W. Ray, 822 Gilmer.
Johnson, Mrs. J. J., 712 Connally.
Long, Mrs. Frank, 516 Church St.
Longino, Mrs. S. Byrd, 504 N. Davis St.
Lynch, Mrs. T. P., 205 Oak Ave.
McConnell, Mrs. T. H., 902 Gilmer.
McGarity, Mrs. T. E., Como.
Pratt, Mrs. R. E., 121 Fore St.
Stevens, Mrs. T. H., 826 Church St.
Stirling, Mrs. Earl, 430 Jefferson St.
Southerland, Mrs. W. S., 334 College St.
Worsham, Mrs. A. B., Oak Ave.

HUNT-ROCKWALL-RAINS COUNTIES AUXILIARY†

Arnold, Mrs. B. F., 1804 Stonewall St.
Becton, Mrs. Joe, 1320 Park.
Bradford, Mrs. H. M., Mineral Heights.
Bush, Mrs. Leslie, 1520 Park.
Cantrell, Mrs. Will, 3414 Lee.

*Address is Sulphur Springs unless otherwise stated.
†Address is Greenville unless otherwise stated.

Cooper, Mrs. J. S., 4104 Lee.
Crim, Mrs. E. Truett, 2506 Park.
Goode, Mrs. E. P., 3605 Oneal.
Hanchey, Mrs. J. M., 1803 Speedway.
Hayes, Mrs. E. R., 2827 Jones.
Kennedy, Mrs. C. T., Jr., 2206 Park.
Kennedy, Mrs. C. T., Sr., 2206 Park.
King, Mrs. H. E., 4312 Wesley.
Maier, Mrs. H. W., 3808 Pine.
Morrow, Mrs. W. C., 2704 Polk.
Peak, Mrs. Fred, Mineral Heights.
Pennington, Mrs. W. E., 3603 Wesley.
Philips, Mrs. W. P., 2101 Park.
Reeves, Mrs. W. B., 2309 Wesley.
Roadman, Mrs. H. C., 3807 Oneal.
Strickland, Mrs. T. C., Mineral Heights.
Swindell, Mrs. J. W., Ardis Heights.
Trentham, Mrs. J. C., Peniel.
Ward, Mrs. J. W., 1612 Park.
Whitten, Mrs. S. D., 4612 Wesley.
Wilbanks, Mrs. M. L., 2905 Henry.

KAUFMAN COUNTY AUXILIARY*

Alexander, Mrs. G. H., 3rd St.
Alexander, Mrs. W. F., 203 N. Rockwall.
Friddell, Mrs. D. T., W. Nash Ave.
Hudgins, Mrs. D. H., Forney.
Jennings, Mrs. A. Y., Mabank.
Lane, Mrs. E. D., Griffith Ave.
Powell, Mrs. George, Box 58.
Scarborough, Mrs. J. W., Box 58.
Sloan, Mrs. Roy C., Box 58.
Thomas, Mrs. William, Box 58.

LAMAR COUNTY AUXILIARY†

Armstrong, Mrs. J. E., 854 S. Main St.
Barker, Mrs. C. D., 1028 13th S. E.
Buford, Mrs. T. W., Minter Rt., Pattonville.
Byers, Mrs. L. A., 2044 Cleveland St.
Fitzpatrick, Mrs. W. W., 637 Clarksville St.
Geron, Mrs. F. C., 1721 Lamar Ave.
Gilmore, Mrs. C. E., 1721 Lamar Ave.
Goolsby, Mrs. E., 547 Fitzhugh.
Hammond, Mrs. D. S., 1249 Lamar.
Hunt, Mrs. T. E., 528 Fitzhugh.
Joplin, Mrs. J. L., Sanitarium of Paris.
Kerbow, Mrs. D. F., 35 9th N. W.
Lewis, Mrs. R. L., 1210 Lamar.
Lewis, Mrs. R. L., Jr., 236 5th N. E.
McCuistion, Mrs. W. W., 1105 Clarksville St.
O'Neill, Mrs. O. R., 546 Pine Bluff.
Parchman, Mrs. Hugh, 306 Church St.
Robinson, Mrs. O. W., 1518 Lamar.
Stark, Mrs. E. H., 818 Pine Bluff.
Stephens, Mrs. J. A., 718 6th S. E.
Stephens, Mrs. L. B., 1428 Clarksville St.
Townsend, Mrs. Courtney, 653 23rd S. E.
White, Mrs. H. H., Lamar Rd.

MEMBERS-AT-LARGE, FOURTEENTH DISTRICT

Kennedy, Mrs. A. B., Bonham.
Lanius, Mrs. John A., 300 W. 6th, Bonham.
Miller, Mrs. Walter S., 2229 Houston Pl., Denton.
Woodward, Mrs. Jack, 901 Ave. C, Denton.

FIFTEENTH OR NORTHEASTERN DISTRICT

Mrs. Ralph C. Cross
Texarkana
Council Woman

BOWIE-MILLER COUNTIES AUXILIARY‡

Baskett, Mrs. Roy, 1324 Hickory.
Beck, Mrs. E. L., Hotel Grim.
Collom, Mrs. Allen, 3016 Pine.
Collom, Mrs. S. A., 621 Main.
Cross, Mrs. Ralph C., 609 E. 39th.
Frank, Mrs. C. H., 3402 Hazel.
Hibbitts, Mrs. William, 2526 Wood.
Kemp, Mrs. Karlton, 1124 Hickory.
Kitchens, Mrs. C. E., 3002 Pine.
Pickett, Mrs. Reavis, 1902 Laurel.
Rives, Mrs. J. H., 2720 Hazel.
Robison, Mrs. J. T., 3019 Wood.
Smith, Mrs. C. A., 2919 Pine.
Tyson, Mrs. Joe E., 2803 Olive.
Watt, Mrs. E. M., 412 Texas.

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†Address is Paris unless otherwise stated.
‡Address is Texarkana unless otherwise stated.

GREGG COUNTY

Cole, Mrs. W. M.
Cook, Mrs. Hardy
Hurst, Mrs. V. R.
Jackson, Mrs. Carl C.
McPherson, Mrs. D. B.
McRee, Mrs. J. T.
Marchman, Mrs. Oscar, Jr.
Markham, Mrs. L. N.
Neihuss, Mrs. H. H.
Roberts, Mrs. Joe
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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION AND PUBLIC HEALTH IN TEXAS

The San Francisco Session of the American Medical Association, the first unrestricted, full-dress meeting of the Association since 1942, seemed to please all who attended, and the attendance was large enough, under the circumstances. The total registration was 7,746, which exceeded by more than a thousand the registration at the last meeting held in San Francisco. Indeed, it was the largest medical meeting ever held on the Pacific Coast. The registration from Texas totaled 222. Excluding the attendance from California, which was, incidentally, 4,287, Texas had the third largest attendance, Illinois with 315 and New York with 297, leading us. Texans are not only avid for the sort of knowledge and experience gained in such a meeting, but they are accustomed to traveling long distances for whatever they want or want to do.

Those who attended the San Francisco session were practically a unit in praising the climate, the hospitality of the people, and the facilities for the meeting. That there should be enough hotel rooms and available meeting places was hardly to be expected. There was a bit of crowding and some disappointments, of course, in this respect, but on the whole conditions were quite satisfactory. The only fly in the ointment was a street car strike, and the fact that San Francisco is replete with steep hills, uphill both ways. Taxicabs did their levelest best to compensate for the disturbance in transportation, but there just were not enough taxicabs. However, the strike let up a day or so before the meeting closed, which helped a lot.

The entertainment features of the meeting were back to normal, or perhaps above normal, as would be the case on the Pacific Coast, particularly in San Francisco.

The scientific work of the meeting was exceptional, even for this great medical organization. The meetings of the scientific sections were well attended, and the exceedingly fine scientific exhibits were constantly crowded. The Section on General Practice of Medicine, recently set up, had a registration of 939, which was the third largest registration of the eighteen scientific sections, the Sections on Internal Medicine and on Surgery alone exceeding that registration.

Texas doctors participating in some capacity in the scientific work of the session were as follows:

Drs. Francis Reichsman, Harold Grant, and T. R. Harrison, Dallas, presented a paper before the Section on Internal Medicine, on "Studies on the Pathogenesis of Peripheral Edema in Congestive Heart Failure (Lantern Demonstration)."

Dr. Curtice Rosser, Dallas, opened the discussion on two papers read before the Section on Surgery, one being on the subject, "Abdominoperineal Proctosigmoidectomy for Rectal Cancer and the Management of Associated Vesical Dysfunction," and the other on "Unique Behavior of the Healing Open Pilonidal Wound and Clinical Complications."

Dr. William F. Mengert, Dallas, was Secretary of the Section on Obstetrics and Gynecology.

Dr. James M. Siever, San Antonio, read a paper before the Section on Obstetrics and Gynecology, on "Clinical Application of Caudal Anesthesia in Obstetrics (Lantern Demonstration)."

Dr. William F. Guerriero, Dallas, read a paper

before the Section on Obstetrics and Gynecology, on "Infectious Granulomatous Lesions of the Cervix (Lantern Demonstration)."

Dr. Everett L. Goar, Houston, opened the discussion of a paper read before the Section on Ophthalmology, on "A Neglected Case of Secondary Glaucoma in Eyes in which the Lens Is Absent or Dislocated."

Dr. Claude C. Cody, Houston, was a member of the Executive Committee of the Section on Laryngology, Otology and Rhinology.

Dr. J. M. Robison, Houston, read a paper before the Section on Laryngology, Otology and Rhinology, on "Pressure Treatment of Allergic Sinusitis (Lantern Demonstration)."

Dr. Homer E. Prince, Houston, opened the discussion of the paper presented by Dr. Robison.

Dr. Arild E. Hansen, Galveston, presented a paper before the Section on Pediatrics, on "Eczema and the Essential Fatty Acids (Lantern Demonstrations)."

Dr. Tinsley R. Harrison, Dallas, was a member of the Executive Committee of the Section on Experimental Medicine and Therapeutics.

Dr. George R. Herrmann, Galveston, read a paper before the Section on Experimental Medicine and Therapeutics, on "Some Observations on Hypercholesterolemia and the Effects of Decholesterizing Agents (Lantern Demonstration)."

Dr. C. F. Lehmann, San Antonio, was a member of the Executive Committee of the Section on Dermatology and Syphilology.

Dr. Arild E. Hansen, Galveston, opened the discussion of a paper read before the Section on Dermatology and Syphilology, on "An Unusual Form in Early Congenital Syphilis."

Dr. J. Bedford Shelmire, Dallas, opened the discussion of a paper read before the Section on Dermatology and Syphilology, on "An Unusual Form of Cutaneous Reaction Following Sulfonamide Therapy."

Dr. A. I. Folsom, Dallas, opened the discussion of a paper read before the Section on Urology, on "End Results Following Nephrectomy in Hypertensive Patients."

Drs. Curtice Rosser and Jack G. Kerr, Dallas, presented a paper before the Section on Gastro-Enterology and Proctology, on "Pilonidal Disease: Present Status of Surgical Treatment (Lantern Demonstration)."

Drs. Charles L. Martin and Carleton C. Wright, Dallas, presented a paper before the Section on Radiology, on "Irradiation Therapy for Cancer of the Face, Mouth and Metastatic Cervical Lymph Nodes (Lantern Demonstration)."

Dr. J. M. Robison, Houston, University of Texas School of Medicine, contributed an exhibit to the Scientific Exhibits for the Section on Laryngology, Otology and Rhinology, on "Pressure Treatment of Allergic Sinusitis."

Drs. H. C. Slocum, E. A. Hoeflich, and C. R. Allen, University of Texas School of Medicine, Galveston, contributed an exhibit to the Scientific Exhibits of the Section on Anesthesiology, on "Malpositions on the Operating Table."

Dr. Olin West, for many years Secretary and General Manager of the American Medical Association, and the soul of medicine in America, recently retired at his own request, was unanimously elected President-Elect.

Dr. H. H. Shoulders assumed the office of President of the Association at San Francisco, thus presenting a very exceptional situation, wherein two distinguished physicians from the same city and state, Nashville, Tenn., occupied the two highest offices in the American Medical Association.

Dr. A. J. Carlson, Chicago, received the Distinguished Service Award, over Drs. Torald Sollmann, Cleveland, and Francis Carter Wood, New York.

The next annual session of the Association will be held in Atlantic City, N. J., June 9-13, 1947. This will be the Centennial Meeting of the Association, for which great preparations are being made.

There will be a meeting of the House of Delegates at Chicago, in December.

The American Medical Association House of Delegates at San Francisco ran true to form, in that an enormous amount of highly important business was transacted. The period of postwar reconstruction seems to have definitely involved the American Medical Association in reconstruction confusion and demands. That its reputation for doing things was maintained, almost goes without the saying.

Texas was represented in the House of Delegates by Drs. Holman Taylor, Fort Worth; F. J. L. Blasingame, Wharton; Howard R. Dudgeon, Waco; B. E. Pickett, Sr., Carrizo Springs, and Edward H. Cary, Dallas, all regularly elected Delegates. In addition to these, the following Texas physicians served as Delegates from Scientific Sections: Dr. Charles T. Stone, Galveston, Section on Internal Medicine; Dr. C. F. Lehmann, San Antonio, Section on Dermatology and Syphilology, and Dr. H. E. Griffin, Graham, was elected a Delegate to represent the newly created Section on General Practice of Medicine.

Dr. B. E. Pickett, Sr., served as a member of the Reference Committee on Amendments to the Constitution and By-Laws; Dr. E. H. Cary served as a member of the Reference Committee on Executive Session, and Dr. F. J. L. Blasingame served on the Reference Committee on Postwar Planning.

This editorial will be in the nature of an unofficial report of the regular Texas delegation, which is by way of being a long established custom, and which it is hoped by the Delegates will serve a good purpose. The published proceedings of the meetings of the House of Delegates of the American Medical Association will be found in full in the following numbers of *The Journal of the American Medical Association:* July 13, 1946, page 905, and July 20, 1946, page 984.

The subject of public relations in general and in several particulars occupied the position of greatest

interest and activity during this particular meeting of the House of Delegates, as was the case with the previous meeting of the House. Discussions and decisions were rather intermingled as between prepayment plans, compulsory health insurance, rural medical service, and so on. We hope to bring to the attention of our readers, the several phases of these important questions. However, we are hopeful that our readers will take the trouble to follow the points of their interest through the Transactions, as published in *The Journal of the American Medical Association*, and already referred to.

A very comprehensive resolution on *Medical Service and Public Relations* was introduced in the House by the California delegation. This resolution opposed compulsory health insurance, and supported the National Medical Care Program of the Board of Trustees calling for the employment by the Association of experienced legislative representatives for the Washington office, with complete authority and full coöperation financially and otherwise, in carrying out the policies of the House of Delegates and the Board of Trustees, and that, which was really the point of the resolution, "the most competent and outstanding public relations counsel that can be found in the United States be employed immediately to bring to the American public the real story of American Medicine." The resolution provided that the plan set out in the resolution should "replace all the organizations that now are endeavoring to do legislative work on a national scale, and eliminate confusion arising from the divergent actions."

Another resolution from California, pertaining to the activities of the *Editor of The Journal of the American Medical Association*, was introduced. Both resolutions were referred to the Board of Trustees as a Reference Committee. This, as it transpired, was because of the fact that the Board of Trustees had already taken such action as would meet the objectives of the California delegation in these and other activities in this connection, at this meeting and perhaps other meetings of the House of Delegates.

As a matter of fact, the Board of Trustees had been investigating the whole problem for some months, and had employed a firm of public relations and publicity experts to analyze the whole problem and make recommendations. This firm came up with a very interesting report, and the Board of Trustees had, for the most part, already taken the advice incorporated in the report. The Bureau of Public Relations of the Association was commended most highly by this firm, as to the dissemination of news pertaining to health and medical activities and medical progress, but it was not so commendatory about other, and equally as important features of publicity. For one thing, these experts believed that *Hygeia*, the health magazine for laymen published by the American Medical Association, should be vitalized and expanded, and that the Editor-in-Chief of the Association should reserve some of his vivid and popular articles for the publication. These experts recommended, also, in short, that the American Medical Association separate definitely the functions of scientific interpretation and medical economics in the direction of public relations. They recommended that all scientific matters he handled by the Editor of *The Journal* with which suggestion, incidentally, the Board of Trustees agreed at once, but withheld approval of the idea of using some vivid articles for *Hygeia*, expressing the opinion that this publication for the layman should be authored by a wide variety of physicians from outside the inner circle. It was decided that the recommendation of the experts that the Bureau of Medical Economics be expanded, and that a person of high caliber be employed for its promotion should be carried out. It will be recalled that the Bureau of Medical Economics has been more or less in eclipse now for some time, new ideas having crowded it somewhat out of the picture. There have been several agencies set up to handle the various problems formerly handled by this Bureau, to the end that there has been more or less confusion and, therefore, lost motion.

The fact that the position of the Association on economic and social aspects of medicine has been defensive and negativistic was deplored by the experts. This recommendation met ready response, and approval by the Board of Trustees who decided to employ an Executive Assistant for the General Manager of the Association, who would have charge of coördinating and servicing the activities of "all officers, councils, bureaus, divisions and departments of the Association in relationship to the profession and general public." This Executive Assistant would, in practice, take over and direct the activities of the Association as they relate to the general public, except for scientific matters, which will remain in the hands of the Editor-in-Chief of the Association. He would be advised by professional public relations counsel, and his advice sought at all times and in all matters. These recommendations were approved and adopted, which is by way of making a long story short.

The resolutions introduced by the California delegation with reference to the activities of the Editor-in-Chief of the Association were withdrawn.

The National Medical Care Program, as worked out by piece-meal here and there, was consolidated and clarified to the extent possible at this time and under the circumstances. Several resolutions on the several phases of the problem were given the consideration that was due them. A resolution at the instance of the Conference of Presidents and Other Officers of State Medical Associations, which met in San Francisco just prior to the meeting of the American Medical Association, insisted upon activation of the policies already adopted by the American Medical Association, which envision a strong program of health legislation. The resolution was adopted. There would not seem to be any reason for this reiteration, but it is basic in any consideration of our medical care program. It was explained that the Trustees simply had not gotten to the problem in due course until very recently.

The Reference Committee on *Industrial Health* strongly approved the Supplementary Report of the Council on Industrial Health, advising that said council, by coöperatively working with management, labor, and the medical profession, can help to promote the health program of the American Medical Association, and very largely lead to approval of the position of the American medical profession in such matters as health insurance, whether coöperative or compulsory.

A resolution from Michigan sought to acknowledge the settlement in the *National Bituminous Wage* controversy as an accomplished fact, so far as it involves health, medical, and hospital service. The resolution sought further to set up a committee or council of the American Medical Association to work out immediately a coöperative plan for caring for the health of miners under the settlement of the coal strike. A resolution from Kentucky asked for a committee to advise with physicians affected by the administration of the health fund set up by the agreement which settled the strike, in order that said physicians might be properly advised concerning their rights and their modes of action under the circumstances presenting so that the ideals and standards of the American Medical Association in such particulars might be preserved.

These resolutions were referred to the Council on Medical Service and Public Relations, with instructions to contact any concerned group for the purpose of protecting the health and welfare of the workers, and maintaining proper professional relations. The Council on Industrial Health will coöperate with the

Council on Medical Service and Public Relations in these matters, as it will with a number of groups dealing with a number of phases of the whole problem of health, with workable plans laid for protecting the health of the public, which plans deal with more ramifications than we can deal with here. The Council on Medical Service and Public Relations, in a supplementary report, had stated that the voluntary prepayment medical care program was moving into high gear. At the time the report was read, thirty-one states had set up plans of the sort, and in twelve states and the District of Columbia, such plans were being actively developed. It also advised that each state should set up its own prepayment plan, and coöperate with existing Blue Cross Plans. The Council politely criticized the insistence that all such plans be wholly without profit. It was thought best to allow all such profits as would safeguard any such organization from stalling or failing. The greatest possible benefits in medical care should be provided for the subscribers.

The Council on Medical Service and Public Relations recommended approval, or acceptance of any coöperative plan in the following words: "The seal of acceptance denotes that (name of plan) has been accepted within the standards set forth by the Council on Medical Service and Public Relations of the American Medical Association." Any such plans to be acceptable must have local approval and professional control, free choice of physicians, proper patient-physician relationship, adequate rates based on sound actuarial principles, relatively inexpensive promotionary activities, with their several and respective implications. A national organization intended to coördinate the numerous state prepayment plans, the "Associated Medical Care Plans, Inc." was approved, and the duties for the corporation are "to assist in the initiation and development of plans in the individual states upon determination of need." The duties of the Council on Medical Service and Public Relations will remain the same as specified in our present By-Laws, with the addition of a new section providing for a division of Prepayment Medical Care Plans under the Council, and for the establishment of standards for prepayment medical care plans. The name of the Council on Medical Service and Public Relations was changed, by amendment to the By-Laws, to the "Council on Medical Service."

Rural Medical Service has been a problem of the American Medical Association now for some years. Mr. F. S. Crockett, Indiana, has long headed a committee working on the subject. The reports of this committee have always been pertinent, and obviously the subject matter has been closely allied with the efforts of the Association to plan an adequate medical service on a feasible, prepayment basis. The committee has been wise in recognizing that the situation is different in various sections of the country, and therefore requires different treatment in many of them. For that reason, there have been sectional conferences from which much understanding has come. For one thing, the committee has determined that organization for rural health service cannot be strictly on a county area basis; it must be on a wider trade area basis. That is a thought that does not enter the heads of our fellows in the more thickly populated sections of the country. A significant statement was made by the committee at San Francisco about the Farm Security Administration care. The committee said that when the farmers came upon better times financially, they just naturally fell out with the Farm Security Administration. It was held that middle-class families, whether rural or urban could pay for the cost of illness, except when the illness is catastrophic. It was figured that insurance distributes this cost, and can so distribute the cost in the lower financial brackets that it can be better borne by the individual. It is the low-income families, both rural and urban, which are the principal concern of those who are trying to furnish adequate medical service for all. The whole discussion pointed to the need of more well-trained physicians who are willing to enter general practice in rural areas, and the hope was expressed that medical colleges would lay more emphasis upon the value of general practice as a medical career.

Thus it will be seen that the problem of prepayment medical plans and rural medical service can and probably will work out together. A resolution was introduced in the House, providing for the establishment of a loan or revolving fund, for the states needing help in setting up prepayment medical plans. The resolution was not adopted, for the reason that the already setup Associated Medical Care Plans, Inc., had the authority to render such assistance, with the support of the Board of Trustees, of course.

Compulsory Health Insurance, of course, received its share of attention, which was considerable. The subject for national debate for the coming year, for high schools, is to be on a national system of compulsory health insurance. This has happened before. The Council on Medical Service and Public Relations reported that a new handbook on the subject was being prepared, in conjunction with the Bureau of Medical Economics. There are other agencies which are putting out handbooks of the sort, and it may be said parenthetically, that the Package Library Service of the State Medical Association of Texas will be ready to fill any reasonable demand for this sort of material.

In answer to the much publicized charge that the doctors of the nation are divided in the matter of support of the Wagner-Murray-Dingell bills, a resolution was adopted, asserting that such is not the case, and that the measure referred to will be harmful and cannot be supported by the medical profession. President-Elect Shoulders reminded us that in such times as these, "the enemies of freedom and the importers of alien philosophies of government find favorable opportunities for their most strenuous activities . . . The people of the United States are faced with the problem of determining the future course of this nation. They are faced with the problem of determining whether that course is back toward our 'American way of life' or toward some totalitarian system which always terminates in tyranny." He reminded us further that in years gone by, the government has set up a number of agencies, including hospitals, completely staffed and organized for the care and health of veterans and other wards of the government and that the staffs of these institutions are not going to be happy in any proposal of lessening their holds on their jobs.

The Reference Committee which dealt with the Address of President-Elect Shoulders, advised that "the situation is not appreciated by the younger men, and we should ever be alert that history does not repeat itself, and allow the same mistake to occur in this reconversion period." In this connection, the reference committee reporting on the address of Dr. Shoulders advised that another statement might be noted. He insisted that the oft repeated charge made by politicians that the activities of the medical profession are negative rather than positive was all wrong, and held that nothing could be more positive than the policies and positions of the American medical profession in these particular matters. He drew a significant differentiation between the "statesmen" and the "politicians."

In order to make assurances doubly sure that the medical profession stands definitely committed against the several measures pertinent in the movement to regiment and socialize the practice of medicine, the House of Delegates formally expressed its opposition to the Wagner-Murray-Dingell bill and the so-called Pepper bill. The Taft-Smith and Ball

bill (S. 2143) was held to be in the formative stage and supporters of a resolution calling for certain amendments to that measure and its tentative support were told to await developments. The Council on Medical Service and Public Relations, in conjunction with the Bureau of Legal Medicine and Legislation, was authorized to confer with the sponsors of this bill and report back to the House of Delegates at the next meeting.

A resolution from West Virginia complained bitterly that the chairman of a committee of the Senate had denied representatives of the medical association of that state the opportunity to appear before the committee in the United States Senate dealing with the Wagner-Murray-Dingell bill. The resolution was supported, with some slight modification.

A letter from Senator Murray, directed to the Chairman of the Board of Trustees of the American Medical Association, very cleverly sought to secure commitments from the Association which might subsequently prove to be embarrassing. Senator Murray asked for a statement as to the position of the American Medical Association on grants-in-aid to state-approved voluntary health programs which are supported by regular contributions by beneficiaries, and whether such contributions should be paid to the institutions or the physicians concerned. The letter asserted that "Such government assistance would encourage enrollment and have much the same result as legislative compulsion, but with freedom for localities to determine the timing and character of their health programs." The House referred the letter back to the Board of Trustees with the advice that it was difficult to evaluate one paragraph of a statement, without having read the entire statement, and the letter had reference to statements made before Senator Murray's Committee by representatives of the Blue Cross Commission, Mr. Mannix and Dr. Rorem.

A side-light on the subject of prepayment plans and compulsory insurance was furnished by a resolution from Rhode Island calling upon the American Medical Association to restudy its decision that an attending physician be not required to certify to an illness in connection with recovery of money lost by virtue of illness. The reference committee to which the matter was referred believed that the position of the American Medical Association in the matter should be that the attending physician sign certificates of illness as required, but that the whole problem be restudied in the light of changed conditions pertaining to such matters.

The Medical Care of Veterans was brought to the attention of the House of Delegates by the Committee on Postwar Medical Service in a recommendation that since the reorganization of the Veterans Administration, under Major Paul R. Hawley, the American Medical Association endorse the establishment of a Medical Corps. The feeling seemed to be rather general that the Veterans Administration is in a position now to organize a medical corps of sufficiently high standing to warrant recognition by the American Medical Association. A resolution was introduced by the Michigan delegation, detailing the plan of Michigan State Medical Society for caring for veterans, organized by the Society, recommending the plan to the various state associations and urging its adoption as a move in the direction of efficiency and uniformity. The reference committee having the resolution in charge, changed the resolution so as to recommend that "medical societies in each state where no plan is now in effect proceed at the earliest possible moment to adopt a program suited to their particular needs and requirements and designed to fulfill the medical responsibilities of the Veterans Administration to the veteran in the closest conformity to the principles of good medical practice." The whole proposition is that the medical profession of the country join the Veterans Administration in setting up a plan or plans looking to the medical care of veterans at home, except in those cases where hospitalization is required. Some state medical associations can, through their ownership or connection with prepayment plans of medical service, enter into contract with the Veterans Administration, as witness the Michigan Plan, whereas other state associations or societies, by virtue of their respective charters, cannot do so. This fact evidently presents a complication which is to be overcome, in view of the acknowledged advisability of providing for the care of veterans by their respective family physicians.

A Wisconsin delegate introduced a resolution which would provide that any physician honorably discharged from military service, who has graduated from an approved medical school in the United States with the degree of doctor of medicine, be allowed to practice medicine in any state, without regard to state lines, or without the necessity of taking examinations or entering into reciprocal negotiations. The resolution was not passed. Nothing could be done about such a matter, in view of the fact that the practice of medicine is regulated by police powers reserved to the states. State lines can be broken down in such matters only under such conditions as obtain in the armed forces. Obviously, when a medical officer leaves the armed forces, he cannot further take advantage of such a privilege.

The Committee on Postwar Medical Service was authorized to set up the American Medical Association *Bureau of Information* on a permanent basis. Thus far it has been a matter of assistance mainly to the returning medical officer. It is thought that the same data and the same information will be of great assistance to the Committee on Rural Medical Service, and to all who need to know something of suitable locations for the practice of medicine, and to those who are in need of the services of physicians. It will be understood that the State Medical Association of Texas has a similar setup, and has rendered this type of assistance all along. It will continue to do so.

Pursuant to a resolution from Ohio, each state medical association has been asked to assume leadership in the development of adequate *Mental Disease Programs* within its boundaries, and to coöperate with other states in stimulating public interest and support of such programs.

Through adoption of a resolution from New York, a change in the *Federal Workmen's Compensation Act* was requested, to the end that insured persons under this act may be treated by the "doctors of medicine" of their choice. The original resolution had said "physicians" of their choice.

A resolution from New York, after amendment, was adopted, declaring that, in adoption of the *Constitution of the Health Organization of the United Nations*, the care of the sick and the social organization related to the practice of medicine be considered problems of concern of the individual nation and not problems for determination by the Health Conference or organization of the United Nations.

Traffic Accidents again attracted the attention of the House of Delegates. It has been so at every meeting for some years. Physicians are urged in a resolution from the Section on Laryngology, Otology and Rhinology, to equip their cars with emergency aid devices and by precept and example assume the leadership in national safety on the highway.

Complaint was made that in many industrial plants, *Non-Medical Personnel* is employed for the detection and management of visual disorders. It was resolved that the House of Delegates "recommend to industry through the Council on Industrial Health that ophthalmologists be consulted respect-

ing the solution of all problems affecting the eyes of workers."

A resolution from Oklahoma called upon the American Medical Association to establish a *Council or Bureau on Medical History*, "committed to the task of discovering sources, accumulation and preservation of historical data, and possibly the periodic publication of historical studies of interest to the members of the Association or of value to the public" and to "coöperate with medical schools in the planning of departments or courses in medical history and with the state medical associations interested in local medical history." The House of Delegates thought it would be quite sufficient unto the occasion that the "various scientific sections incorporate in their programs occasional papers dealing with the history of medicine; that *The Journal* be encouraged to solicit papers pertaining to this subject and that the Board of Trustees be asked further to give consideration to the establishment of some suitable committee to encourage medical schools and state and county medical societies to take cognizance of the need for this educational activity."

Failure of the *Surgeon General of the United States Army* to receive rank comparable with that of the Surgeons General of the Navy, and other services or branches of the armed forces, was called to the attention of the House of Delegates from New Jersey. The decision was that a committee be appointed to "inquire into the general situation of the military rank accorded doctors of medicine during World War II."

A resolution was introduced at the instance of the Conference of Presidents and other Officers of State Medical Associations, calling upon all medical associations not already maintaining full-time headquarters, to establish such offices, with all possible dispatch, in accordance with the need and financial resources of the associations concerned. The House of Delegates decided that while it was "highly desirable for each state association to maintain a full time headquarters office, this decision should be left to such associations."

A resolution from the Section on Anesthesiology sought to bring up the Banquo's ghost of *Who Discovered Anesthesia*, and settle the matter by according the honor to Massachusetts. The effort created a flurry, but it was rather expeditiously decided that the whole matter should be tabled, which happened promptly.

A resolution from the Section on Anesthesiology declaring that the presentation of bills and the collection of private fees for medical services by other than recognized physicians, in connection with the *Practice of Anesthesiology*, be established as evidence of the practice of medicine, was promptly tabled. There was no disposition to evade the issue as to whether the practice of anesthesiology is the practice of medicine. Rather, it seemed that no one could see the point in passing the resolution as written.

A resolution from the newly created Section on General Practice of Medicine called upon the House of Delegates to voice its approval of the establishment of *Sections on the General Practice of Medicine* in the various states and county societies that are a part of the American Medical Association, and in the hospitals approved by the Council on Medical Education and Hospitals. The resolution was adopted, except for that part referring to hospitals, which part seemed rather beside the point so far as the American Medical Association was concerned.

A resolution from North Carolina called for review, clarification, and *Revision of the Principles of Medical Ethics* of the American Medical Association. The resolution was adopted and the matter referred to the Judicial Council, with instructions to act. It will be recalled that this problem has been almost constantly before the House of Delegates now for a number of years. There is no doubt but that the document needs amending, but not in the way most of the advocates of such procedure would have it done. Most doctors look upon the Principles of Medical Ethics not as "Principles," but as "laws," or "rules and regulations," or "statutes." It is none of these things. It is like the Ten Commandments. The only "Principles" ever amended so as to bring in any appreciable amount of detail, is that pertaining to Contract Practice, and it must be said in all fairness that the Principles pertaining to Contract Practice have been made more understandable and less controversial by the explanatory amendments added a few years ago. It is the hope and expectation of those who know what it is all about, that some helpful changes can be added without robbing the document of any of its value as Principles.

A number of *Amendments* were proposed for the *Constitution and By-Laws* of the Association, some of which were adopted, and some of which were rejected. Perhaps the most important amendment adopted pertained to the regular sessions of the House of Delegates of the Association. This amendment provided that the House of Delegates shall meet annually, on the Monday preceding the opening meeting of the annual session, as at the present time, but that there shall be a *Supplemental Session* in the interval between the annual sessions, the time and place of such meetings to be fixed by the Board of Trustees, and that any business proper to be brought up at any regular meeting of the House of Delegates may be given attention during the supplemental meeting.

A resolution was introduced, proposing that the Council on Medical Service and Public Relations comprise an *Interim Committee* to deal with matters of policy between meetings of the House of Delegates, so that immediate action may be taken, particularly in connection with legislative developments at Washington. The reference committee having the resolution in charge, recommended that it not be adopted, for the reason that it would require an amendment to the By-Laws. According to the By-Laws, interim authority is vested in the Board of Trustees.

An amendment to the By-Laws was introduced requiring "unanimous consent for the introduction of new business not filed in proper form with the Secretary of the Association thirty days before the annual session of the House of Delegates, except when presented by the Board of Trustees, the Officers of Sections, or by instruction of constituent associations by action taken within such thirty day period." The intent of the proposed amendment was recognized at once as being excellent. There was no doubt but the proceedings of the House would be greatly facilitated were the proposal feasible, but it was felt that it would be rather "dangerous to freeze into law a requirement that resolutions must be introduced so far in advance of a session, and to prohibit the introduction of new business without unanimous consent unless these provisions have been complied with." The amendment was rejected, but it was decided that a resolution should be adopted stating that "*Resolutions should be introduced at least thirty days prior to any meeting of the House*, and that such resolutions be published in *The Journal* and in the Handbook of the House of Delegates." The Secretary of the Association was directed to advise constituent associations of this policy, and request compliance therewith to the extent possible.

A resolution was adopted which had the effect of a By-Law, in that it required the *appointment of Reference Committees* of the House of Delegates at least two weeks before a meeting of the House. The purpose of this action was, of course, to give refer-

ence committees an opportunity to study the published reports, resolutions, and the like, before the House convenes and such matters must be acted upon. No doubt this procedure will be helpful, but we would like to say parenthetically, that we will find more and more "supplemental reports" reaching the House of Delegates from officers, councils, and committees, because of the effect of the thirty-day resolution already adopted.

An effort was made to amend the By-Laws so as to *require a Fellow to subscribe to The Journal of the American Medical Association.* It was determined that the present method of handling this particular matter was as effective as the proposed new method would be, and that it would be better to let good enough alone in this particular. The amendment was adopted, however, as it clarified the section of the By-Laws concerned, but it simply provided that Fellowship shall "include" subscription to *The Journal of the American Medical Association.*

Proposals that the By-Laws be so changed as to provide for *Scientific Sections on Physical Medicine and Allergy,* were rejected, pending development of greater demand for such sections.

The By-Laws were amended so as to change the name of the "Council on Medical Service and Public Relations" to the "*Council on Medical Service.*" References to that Council in this editorial have been in accordance with its designation in the Transactions.

A committee was appointed to consider and report upon a *complete revision of the Constitution and By-Laws* of the Association. The committee is to report at the next meeting of the House of Delegates, and be ready with its final report not later than the next following meeting of the House, which would be the meeting during the next annual session of the Association.

Appointment of Delegates.—It will be remembered that the House of Delegates of the American Medical Association comprises 175 members. Each of the Scientific Sections has a delegate, and the Army, the Navy, and the United States Public Health Service, each has a delegate. The other delegates are apportioned among constituent associations in proportion to the membership of each. This distribution is made every three years, and this was the third year. We had confidently expected that Texas would gain a delegate this year. It will be recalled that we formerly had six delegates. We have five delegates now. However, the apportionment was made on the basis of one delegate for each 1,000 members or fraction thereof. The total membership of the American Medical Association on April 1, 1946, was 126,835. On this basis, California, the District of Columbia, North Carolina, and Oregon, each gained one delegate, and Mississippi, Ohio, and Pennsylvania, each lost one delegate. The creation of the Section on Practice of General Medicine added a delegate, and the independence of the Philippines removed two delegates. We were lucky to hold our own.

The Secretary of the Association reported that Texas had a membership of 4,852, which was sixth in the list of memberships by states. However, Texas was shown to have 2,255 Fellows, which was eighth by states. According to the last American Medical Association Directory, Texas had 6,952 physicians, which was sixth in the list of states. It would seem that we are doing well enough in the way of membership, but are not doing so well in the matter of Fellowships. It would seem that we could do better.

The Trustees reported the Association as having total assets of $7,798,153.54. The net worth of the Association on December 31, 1945, was $7,353,889.23. The income in excess of expenses of the Association for the year was $990,708.81. The total income for the year was $1,687,452.79.

The publications of the Association, including bad debts and everything, cost $1,787,575.19.

The income from these publications was $3,253,-096.80. We mention these figures not as a comment on the Auditor's Report, but in order to show that the American Medical Association is a large and thriving enterprise.

Among the publications of the Associations, *The Journal of the American Medical Association,* of course, easily ranks first. The net paid weekly average circulation of *The Journal* in 1945, was 111,407, compared with 109,828 the year before.

Not the least important among the publications of the American Medical Association, and some think it is second in importance, is the *Quarterly Cumulative Index Medicus,* without which it would be next to impossible to conduct any orderly research into the medical literature of the world, or even our own country. Only two issues of this publication were put out in 1945, because of paper shortages. At that, 15,229 foreign language articles were indexed during the year. That is 63 per cent of the foreign articles indexed the year before. This publication cost the Association a net loss of $16,722.08, comparable to a loss of the year before of $9,131.89.

Hygeia, the periodical for the health education of the public, is now on a firm footing. It is probably the most quoted health periodical in the United States. The net paid circulation of the publication for 1945, was 143,105, as compared with 135,685 in 1944. The financial statement showed a gain of $108,214.21, compared with the figures $68,117.81 for 1944.

The nine special journals of the Association increased in circulation to a considerable extent, except *Archives of Surgery,* which suffered a small loss. *War Medicine,* of course, is out of the picture, and a new publication, "*Occupational Medicine,*" takes it place. The net income from the nine special publications for 1945, was $118,448.46, which exceeds the 1944 net income from these publications by $10,486.09.

The several Councils of the Association have functioned notably. It is not possible to present here anything like a comprehensive account of these activities, and nothing short of that would be interesting or informative.

A Highly Valuable Gift to the Library was made recently by Dr. Walter G. Stuck, of San Antonio. The gift consists of a collection of 5,054 reprints on orthopedic subjects, accumulated personally by Dr. Stuck during the past fifteen or twenty years. The reprints are, of course, of the best articles appearing in orthopedic literature of the world. The collection had been indexed by Dr. Stuck to meet best his individual needs, but decision was made to reclassify the articles in accordance with the *Quarterly Cumulative Index Medicus* as are the more than 100,000 reprints in the Library available for the Package Service. It was the desire of the donor that they be filed to render the greatest service possible. While they will be available for lending on request by subject, as are all the other reprints in the Library, each will be identified as a part of the "Dr. Stuck Collection of Orthopedic Reprints" so they may be kept intact as a unit when not

out on loan. A suitable plaque will also identify the collection to visitors to the Library.

This is the second collection of reprints received as a gift to the Library, each having been carefully accumulated by the donor. The first such collection received, much smaller but a valuable one on coccidioidomycosis, was given by Dr. Victor E. Schulze, of San Angelo.

The valuable gift reported here emphasizes again the pressing need of the Association for a fireproof building in which to house the Library. The need could not be more urgent. A disastrous fire could sweep away in one night or day a library now serving physicians all over Texas with a package service, that could not be replaced in a short period of time with one million dollars, or any amount of money. Some of the materials in the present library could never be replaced, and the reprints and journals which make possible the package service could be accumulated only over another period of fifteen or twenty years. A fireproof building is needed for the Library of the State Medical Association—not next year or some time, but now! What are we going to do about it?

The Shortage of Nurses in the United States, which before the war amounted to some 10,000 for civilian hospitals alone, has become increasingly acute with the necessity of the Army, Navy, and now particularly of the Veterans Administration, to care for war casualties. In addition, more nurses are being required by a civilian population encouraged by prepaid hospital and medical insurance and by other educational means to be more hospital and health conscious than ever before. It is estimated by the American Hospital Association that 45,000 student nurses, including the 15,000 already enrolled, will be necessary this fall to take care of the demands of the next few years. Unfortunately, drops in admission have been noticeable recently at most schools of nursing throughout the country. For example, in Texas the thirty-seven nursing schools had only 300 admissions in the spring this year as compared with 1,081 in 1941, 1,443 in 1944, and 1,137 in 1945. Some of the reasons behind this significant decrease in student admissions are the discontinuance of the U. S. Cadet Nurse Corps, which was active during the war years; the relaxing immediately following the war of efforts toward recruiting nursing students; the prevalence of attractive openings with good salaries in other fields; and the popular belief that salaries and working conditions for nurses, which in the past may not have been exceptionally pleasing, have not been sufficiently improved to warrant serious consideration of nursing as a vocation.

In line with a national campaign to educate the public with regard to the serious nurse shortage which exists, and especially to promote recruitment of student nurses for the fall enrollment, the Texas League of Nursing Education and the Texas Hospital Association, backed by the State Medical Association, Texas Graduate Nurses Association, State Organization for Public Health Nursing, and Texas State Board of Nurse Examiners, have opened a drive to publicize the advantages of a nursing career with the hope that Texas nursing schools will have a full quota of students in the fall. A meeting of representatives from the groups named above was held in Dallas in June to lay plans for concerted action. It was pointed out then that Texas physicians may be of great service to the entire field of medicine and public health by giving their united support to increasing the number of qualified nurses available to civilian hospitals, Veterans Administration hospitals, nursing education institutions, private duty, doctors' and dentists' offices, and the many other posts where competent nurses are badly needed.

Particular attention has been called to the fact that veterans, both men and women, may receive nursing education at government expense under provisions of the G. I. Bill of Rights, whether they wish to study nursing for the first time or whether they wish to complete interrupted training or to take refresher courses. It is also important to note that personnel policies and salaries are being improved for nurses at Veterans Administration and U. S. Public Health Service hospitals and that similar improvements in civilian hospitals in Texas have been recommended by the Texas Graduate Nurses Association and the Texas Hospital Association and will doubtless be adopted generally.

It is not difficult to realize that if nurses already trained cannot be persuaded to remain active, and if qualified young people trying to decide what vocation to follow cannot be induced to consider strongly the possibilities which nursing offers for service to humanity and for satisfaction and security to the nurse, the shortage will grow worse. Physicians must take a personal interest in the situation, for it directly affects them and their work. They should consistently create opportunities to encourage qualified young persons to secure up-to-date information regarding the career of nursing, and endeavor to guide them into the nursing profession.

CURRENT EDITORIAL COMMENT*

Asphyxia Neonatorum Livida.†—The prevention and treatment of this condition require understanding of the respiration of the infant *in utero* and the changes at birth. The physician's main interest is in the human fetus and newborn but knowledge is based largely on the newborn lamb and this knowledge must be applied to each problem in asphyxia neonatorum.[1]

Early in fetal life stimulation of the skin causes reflex movements which become easier to elicit and more vigorous as the spinal cord develops. At this stage even moderate anoxia depresses them. Later the forebrain increasingly inhibits these reflexes and the fetus remains still unless stimulated or asphyxiated. Then movements are violent. Such movements may arise from asphyxia of the mother, from postures which impair the uterine blood supply, or from obstruction to the cord; the movements are more noticeable when the mother is asleep, depressed circulation and respiration causing slight uterine ischemia. At this time if the asphyxia is severe the increase of reflex activity due to release of cerebral inhibition will give way to depression and abolition of all reflexes.

Slow rhythmic respiratory movements appear early and produce an inward sucking of the ribs. These movements are accelerated by violent fetal activity but not by asphyxial changes in the fetal blood. Later the forebrain stops these respiratory movements except when it is depressed by anoxia, anesthesia, or section of the brain stem.

Thus we see that in addition to the placenta, which is adapted to intrauterine respiration, there develops an adult type of respiratory system which is already coordinated with muscular activity and in which cortical control from higher centers is already established before birth.

The establishment of normal breathing at birth has several causes. The newborn is stimulated by cold. Direct cutaneous stimulation is in part responsible for the first breath. The cold and the effects of gravity combine to initiate reflex tonus which increases the metabolic rate and carbon dioxide production. Anoxia of the fetal brain caused by disturbances both to the uterine and placental circulation during the second stage of labor may depress the cerebral cortex and increase the reflex tone and the metabolism. Finally the placenta, aging and outgrown, separates from the uterus and becomes thrombosed, making the necessity for another respiratory mechanism paramount.

Any of these stimuli may start respiration in a newborn if the respiratory center is not depressed by anoxia or pharmacological agents since most infants start to breathe promptly if they are protected against anoxia during birth or depression by analgesics and anesthetics before birth.

When prevention has failed, two courses are open. Anoxia should be vigorously combated by oxygen and gentle ventilation; cutaneous stimuli to tonic and reflex muscular activity may be artificially provided. The custom of guarding the newborn against the natural stimuli of cold, gravity, and mechanical contacts is open to question. There is no experimental evidence that the infant whose medulla is adequately oxygenated needs more carbon dioxide than it produces by its own metabolic processes nor that additional carbon dioxide can combat drug depression.

Details of the central respiratory control have been described by Lumsden[2] and his work has been used to explain various common respiratory arrhythmias in the newborn. Careful study of this field will be profitable.

The foregoing discussion assumes that there is no structural damage. Brain trauma, however caused, may interfere with these mechanisms. If the trauma be in the pontine or upper medullary regions, it is liable to interfere with both respiratory and cardiovascular mechanisms, producing white asphyxia. Treatment of white asphyxia is controversial, unsatisfactory, and often tragically incomplete.

By contrast the newborn subjected to uncomplicated oxygen lack is remarkable in its tolerance and in the rapidity and completeness of its recovery when oxygen is delivered to it effectively.

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*This department of the JOURNAL presents editorial comments on current items pertaining to the science, art and practice of medicine, contributed by members of the State Medical Association and scientists closely associated with the medical profession of Texas. Invitation is hereby extended to any member of the State Medical Association of Texas to submit such discussions for this department. The discussions should not be more than 500 words in length.

†Read at the Pediatric Postgraduate Course, University of Texas School of Medicine, November 12-17, 1945.

PENICILLIN INEFFECTIVE FOR TETANUS

A clinical study of 16 cases of tetanus failed to show evidence of any beneficial effect from penicillin treatment, according to a report in the January 12 issue of the *J. A. M. A.* by W. A. Altemeir, M. D., University of Cincinnati College of Medicine and Cincinnati General Hospital.

CHOLESTEROL LEVELS IN VARIOUS DISEASES AND THE EFFECTS OF DECHOLESTERIZING AGENTS

GEORGE R. HERRMANN, M. D.*
GALVESTON, TEXAS

Atherosclerosis is the pathological process responsible for more deaths than any other single lesion. It is of most serious moment when it develops, as it frequently does, subintimally in secondary arteries in vital areas such as the coronary bed. The condition once established has always been considered irreversible, and the treatment usually recommended was indirect or palliative and associated conditions such as hypertension, diabetes mellitus, or myxedema received attention. The increasing frequency of complicated atheromatous coronary artery disease in young men with hypercholesterosis and hypothyroidism has interested me during the past decade. Some of these patients improved on thyroid extract. The older physicians and some modern clinicians have prescribed as a vascular alterative, potassium iodide, and as vasodilators, xanthine salts. The growing volume of evidence of the importance of atherosclerosis has led to increasingly intense investigation of the disease process,[1] and this present search for counteracting agents.[1, 2, 3, 4, 5]

The pathogenesis of atherosclerosis has not yet been completely established.[2] The problem has been intensely studied by the histopathologist and repeatedly attacked by the experimentalist. The relationship between cholesterol metabolism and atheromatous vascular disease has been emphasized by several pathologists and some clinicians. The experimental production of atheromatous lesions has been accomplished repeatedly in herbivorous animals[1] by the feeding of diets high in cholesterol, and the further addition of thyroid depression has been followed by atheromatous disease in carnivorous animals. The initiating factors are still not clear. The formation of excessive amounts of cholesterol and esters in the livers of cholesterol fed rabbits and the phagocytosis of excess cholesterol by the reticulo-endothelial system, the escape of heavily cholesterolized phagocytes into the circulation, and the penetration of the intima of small arteries have been demonstrated by Leary.[8] The factors that lead to the localization of such subintimal infiltration may be, according to Hueper,[7] endothelial damage and increased permeability of the arterial intima incident to local impairment of oxygenation and nutrition of the area.

Areas subjected to increased pressure or eddies, as at the bifurcations of secondary arteries especially where there is sharp angulation and areas around orifices of vasa vasorum, are apparently points of predilection for the deposition of a "soft" cushion as the body's possible effort toward compensatory protection. Hueper[7] admits that if the blood plasma is supercharged with cholesterol or lipids forming emulsions, there may be a retention of the fats in the proliferating endothelial cells. It might well be that in the presence of hypercholesterolemia and a permeable intima, small plaques may increase in size by imbibition with the ultimate development of occluding atheromata or rupture with local thrombosis. The infiltrating phagocytes containing crystalline and fluid cholesterol in high concentration in the subintimal stratum may exert pressure and mechanically produce ischemia and interfere locally with the nutrition and thus increase the irritability of the arterial wall. These pathological processes stimulate the reparative invasion of fibroblasts and angioblasts into the arterial wall, with, later, necrosis, hyalinization, and calcification.

CLINICAL STUDIES

The data recorded in table 1 are quite similar to those reported from other medical clinics.[9] The 50 normal persons average

TABLE 1.—*Blood Cholesterol and Esters in Health and Disease.*

Diagnoses	No. Cases	Total Mean	Esters Mean	Total Max.	Esters Max.	Total Min.	Esters Min.
Normals, no cardiovascular disease	50	193	153	275	202	160	120
	S. D.	+24	+22				
Atheromatous coronary artery disease with coronary thrombosis, mitral insufficiency, angina pectoris	120	254	192	500	330	180	120
	S. D.	+42	+37				
Hypertensive heart disease with and without congestive failure	76	235	183	380	272	166	122
	S. D.	+54	+37				
Diabetes with and without peripheral vascular disease	25	243	190	312	205	182	133
	S. D.	+41	+42				
Cancer	30	218	165	423	336	148	112
	S. D.	+50	+41				
Cirrhosis, reversible and irreversible	40	219	162	423	336	148	112
	S. D.	+46	+27				
Hepatitis with and without jaundice	21	239	134	372	190	148	110
	S. D.	+49	+27				
Hypo- and hyperthyroidism	20	239	177	520	410	166	97
	S. D.	+81	+65				
Syphilis	15	238	177	308	226	170	128
	S. D.	+43	+27				
Rheumatic heart disease	15	234	173	285	260	190	147
	S. D.	+36	+43				

S. D.=Standard deviation.

*With the technical assistance of Anna H. Williams, Mae S. Cox, H. Tom Leigh, and John Prewett.

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Read before the Section on Medicine, State Medical Association of Texas Annual Session, Galveston, May 7, 1946.

slightly higher than usual because of the inclusion of several in which the basal metabolic rates may well have been found low if they had been determined. The 120 patients with definite evidence of coronary thrombosis showed the highest averages: total cholesterol plus 33 per cent, cholesterol esters plus 26 per cent; the majority of individual levels of lipids were high, but there were some few with low normal values. The 76 patients with chronic hypertensive disease showed plus 23 per cent and plus 27 per cent mean levels. Many of these had myocardial insufficiency probably due to coronary atheromatosis. The hypertensive patient without the tendency to superimposed atheromatous disease is a rare person.

The 25 patients with diabetes were, for the most part, sugar free and under good control, yet the mean values were high, plus 25 per cent and plus 26 per cent. The 30 cancer patients averaged slightly above normal, plus 13 per cent and plus 8 per cent, as did also 40 patients with cirrhosis of all types, with levels of plus 13 per cent and plus 11 per cent. The 21 patients with hepatitis, most of whom had jaundice, showed high total mean cholesterol levels of plus 22 per cent, but subnormal values for cholesterol esters, which may be taken as an index of the disturbed state of the liver.

Thyroid disease in the series of 20 cases gave high mean cholesterol values, plus 24 per cent total cholesterol, but only plus 11 per cent values for cholesterol esters, again suggesting liver damage. In general, hypothyroidism gave high values, but this was not invariably so, and in several older patients, hyperthyroidism was also accompanied by high cholesterol levels. Not included in this case series as thyroid disease were 15 of the 120 cases of coronary thrombosis which occurred in young men with hypercholesterolemia and lowered basal metabolic rates. Most of these were decholesterized with thyroid extract in small doses over long periods of time, but an occasional case was refractory.

Patients with chronic syphilis and chronic rheumatic fever showed plus 23 per cent and plus 11 per cent and plus 21 per cent and plus 13 per cent values for total cholesterol and cholesterol esters, respectively. Many of these had associated congestive heart failure, but some, without myocardial insufficiency, had high total cholesterol and cholesterol ester levels.

BLOOD AND TISSUE CHOLESTEROL CHEMISTRY

Cholesterol, the highly complex, unsaturated, monohydric alcohol $C_{27}H_{25}OH$, is related to fat only in that it forms a series of esters, organic phosphate salts with the common fatty acids. These are found throughout the animal organism, particularly in blood, bile, milk, liver, kidney, adrenal tissues, ovaries, testes, skin, and egg yolk in high concentration. Man can synthesize cholesterol from acetic acid, but most of it is probably gotten exogenously from foods. The reticulo-endothelial system probably plays an important role in the metabolism of cholesterol, most of which is conjugated in the liver and excreted in the feces. Any excess is seemingly handled with difficulty. Some is utilized by the endocrine system which regulates the levels to some extent. Degradation of cholesterol during hormone synthesis, especially progynon A, is considered to be a source of carcinogenic substances.[10] Cholesterol, some of which is free and most of which is esterified, however, seems to be deposited in pathological processes, particularly in fatty degeneration and in atheromatosis.

Blood cholesterol levels, both the total and the esters, and the phospholipids vary some from time to time in a given normal person, but the limits are such that comparable data may be obtained and general trends in lipid metabolism may be followed[9] even though all fractions of the serum lipids vary widely. The relative proportions of certain constituents, such as the ratio of the free to the total and of cholesterol to lipid phosphorous, are quite restricted in their variability. Repeated observations during the course of study and the calculation of interrelationships are most important. Only extremely abnormal single observations are of significance.

CLINICAL AND EXPERIMENTAL OBSERVATIONS

A large series of determinations of total cholesterol, cholesterol esters, and phospholipids in the plasma of normal persons and patients with various diseases have been made in an effort to establish general trends. A number of these patients were treated with various decholesterizing procedures, such as low fat diet, potassium iodide, thyroid extract, alcaucil, berenjena, choline, methionine, and inositol, and the analyses were then repeated.

Several series of old hens with naturally occurring subintimal atherosclerosis have been simultaneously studied with the same objective in mind.[5] Some definite evidences of decholesterization have been demonstrated in these experimental studies.[5] The blood and tissue levels of lipid are high in old hens of high egg producing stock that have been kept on a high fat (4.5 per cent) and protein (20 per cent) laying mash diet such as purina.

Choline, methionine, inositol, and berenjena have been successful in considerably reducing the blood lipids in the aorta, heart muscle, and liver[5] after four to twelve weeks.

These findings suggested that the decholesterizing agents in some way contributed to the utilization of the lipids in the blood and to the mobilization of lipids from abnormal depositions in tissues, and the possible use of the degradation products in the body economy. The lowering of the levels in the plasma may facilitate the transfer from plaques through the intima as has been suggested to me by Professor B. M. Hendrix.

DECHOLESTERIZATION STUDIES

The possibility of accomplishing decholesterization of tissue deposition was suggested by a mass of experimental proof that has been abstracted from the biochemical researches of Best, Dragsted, Entenman, Montgomery, Chaikoff, Du Vigneaud, McHenry, Patterson, and others.[6] The lipotropic factors, such as pancreatic extracts, lipolysin and lipocaic, choline and methionine, have been found to be effective in the fatty cirrhosis that results from the nutritional defect incident to alcoholism. Confirmation of this and a brief survey of the literature and an analysis of a series of cirrhosis cases was published in this JOURNAL by Herrmann and Rockwell.[6]

These experiences with lipotropic agents capable of mobilizing lipids from the fatty liver led me to wonder if similar effects might not be accomplished in cases with subintimal fatty depositions of atheromatous arterial disease. Of course, one could not expect such prompt dramatic results, for the aorta is not of the same high order of metabolic activity as the liver. However, the abnormal depositions are known to be chemically quite similar and the investigations therefore seemed justified.

THERAPEUTIC APPROACH

Atheromatosis has been regarded as a permanent condition, once established, and highly refractory to treatment. There has been no rational therapeutic precedure for atherosclerosis. Prophylactic measures against the atheromatous degenerative processes are always recommended, but no specific method has been established. A clinician who sees great numbers of patients with evidences of coronary atheromatosis cannot help being impressed by the hereditary factor, the type of person afflicted, and the similarity of habits of the victims. Excessive use of tobacco and high intake of rich foods, dairy products, and animal fats seem to contribute. It is quite possible that the ability to metabolize cholesterol is individual and is very low in some types of persons after infancy and childhood. A few may retain and may use throughout a long life the effective mechanisms of infancy for the efficient handling of dairy products. The yolk sac is rich in cholesterol, and milk, cream, butter, and fat meats are likewise, and these are foods for the very young. Man is about the longest lived animal that continues on a high intake of cholesterol and rich animal food products into adult life, at the same time exposing his vascular system to toxic agents and strain. The old saying that some men dig their graves with their teeth may well be true. Combinations of many factors most likely contribute, but among these must be considered hypercholesteremia.

DECHOLESTERIZING REGIMES

A Low Fat Diet with potassium iodide was used in 13 patients with atheromatous disease, and blood cholesterol, cholesterol esters, and phospholipids were determined before, and, in some cases, after one to two months and, in others, after about one-half to about one year. Reduction in total and esterified cholesterol levels amounted to from 5 and 3 per cent to 23.6 and 14.5 per cent with an average of 15 and 9 per cent.

Thyroid Extract was prescribed in daily doses not to exceed 100 mg. per day in 18 patients with very high blood lipids, and all but 3 had atheromatous coronary disease and basal metabolic rates of —30 per cent to —11 per cent. Two showed 45 per cent and 31 per cent lowering of total and esterified cholesteral levels, respectively, after 14 months; 8 showed decrease of 30 to 25 per cent in twelve months; 2 showed 25 and 18 per cent after eleven months, and a third of the patients showed only 7.5 and 5 per cent reduction after ten to six months of thyroid extract therapy.

Choline was administered in 1 Gm. doses three times daily to 35 patients for periods of one month to three and three-fourths months, an average of two months, with an average of 20.5 and 18.5 per cent reduction in cholesterol totals and esters. Three patients showed actual rises after beginning to take choline; usually the levels dropped upon continuation of the treatment. The general tendency was toward lower levels, but usually only after six weeks of treatment, and thereafter there were lesser grades of change.

Methionine in 0.5 Gm. doses three times daily was used in 4 patients for periods of two to four weeks with average reductions of 15 and 10 per cent of cholesterol and cholesterol esters, respectively. One patient, however, showed rises of 33 and 34 per cent.

This amino acid has probably been used in too small a dose and more studies are necessary.

Inositol in 0.5 Gm. doses four times daily, a daily total of 2 Gm., was administered to 9 patients for an average of twenty-five to thirty days with an average reduction of 14 and 13 per cent of cholesterol and cholesterol esters, respectively. One patient showed no change whatsoever in levels after a month of treatment. These findings warrant more extensive study.

Alcaucil, a powder of Cynara Scolymus, was given in 1 Gm. doses three times daily to 10 patients with high blood cholesterol levels with satisfactory results. There was an average lowering of the blood total cholesterol and cholesterol esters of —24 per cent and —23 per cent respectively, in 7 cases, no change in 2 cases, and a rise in 1 case.

Berenjena, a powder of Solanum Melongena L., has been administered in 1 Gm. doses to only 4 patients with hypercholesterolemia with moderate effect in 2 and very little effect in the other 2, giving rather low average results of 11 and 8 per cent reductions, respectively, in total cholesterol and cholesterol esters.

SUMMARY

It is evident that gradual decholesterization may be accomplished by the sharp restriction of the patient to a low *fat diet* and by giving potassium iodide and thyroid extract over a period of months or years.

More effective and more rapid decholesterization follows the use of *choline, methionine, inositol, alcaucil, and berenjena.*

The lipotropic agents cause no disagreeable secondary effects. The patients with rare exception have reported feeling better with a reduction of the frequency and the severity of distress or pain in the chest.

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ABSTRACT OF DISCUSSION

Dr. James A. Greene, Houston: Dr. Herrmann is to be congratulated upon the very excellent presentation and the different approach to an old subject. There are a few points, however, that I think should be emphasized.

In the first place it was shown by Newburgh and Altshuler that a high fat diet did not produce arteriosclerosis in their patients any more frequently than in persons with diets of average composition. Elmer Sevringhaus at Wisconsin confirmed their observation. It is known, however, that obesity has been thought to be a very definite factor in the production of arterial disease. A few years ago during the study of 300 cases of obesity, 66.67 per cent of these people had hypertension, which was far greater than that of the average run of the population.

I have observed recently that some diabetic patients with vascular disease appear to have a disturbance in the oxidation of dextrose and that these patients do better when they are placed on a low fat, high carbohydrate diet.

Dr. Herrmann, closing: I wish to thank Dr. Greene for his discussion and kind remarks. I cannot agree that proof has been furnished that the high fat diet does not contribute to hypercholesterolemia and to atheromatosis.

The state of the vascular intima is probably the most important factor in the local development of a subintimal atheroma but hypercholesterolemia is the next most important factor and it is apparently amenable to treatment. We seem now to have a method of attack even though we do not yet know the enzyme system involved in fat metabolism.

The finding of a high blood cholesterol level calls for decholesterizing agents.

I wish to acknowledge my indebtedness to Professor Byron M. Hendrix, head of the Department of Biochemistry, University of Texas Medical Branch, for much help and encouragement during the progress of these experimental and clinical investigations.

POISON REACTION FROM 'COLD WAVE'

An acid used in the process of hair curling known as a "cold wave" has been found to produce symptoms of poisoning in allergic and anemic persons, according to Lawrence H. Cotter, M. D., of New York.

Writing in the June 15 issue of *The Journal of the American Medical Association*, Dr. Cotter, who is from the Department of Medicine, College of Physicians and Surgeons, Columbia University and the Presbyterian Hospital in New York, says that the "cases in which a toxic reaction has been observed appear to be on the increase."

Experience with patients having thioglycolic acid poisoning indicates, the author says, that "persons suffering from allergies and anemias are the most likely victims, but the acid has an established affinity for the protein molecule, and liver damage to some extent may be anticipated from prolonged exposure in any individual." However, in the majority of cases recovery occurs without permanent liver damage when the exposure is promptly terminated.

Some of the major symptoms noted among the patients have been swelling of the face, arms, and legs, appearance of an itching rash, and loss of hair.

INFECTIOUS HEPATITIS

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This is a report of 52 sporadic cases of infectious hepatitis observed during 1943-1945. The study was undertaken to compare the clinical features of the sporadic cases with those of epidemic nature reported in the literature. All cases to which serum, drugs, or infection might be considered a contributing factor were eliminated from this study.

The disease has been known for a long period of time; in fact the literature has various synonymous terms for this disease, some of which are acute infectious jaundice, acute infectious hepatitis, epidemic hepatitis, acute catarrhal jaundice, and epidemic catarrhal jaundice. Only recently have these diseases been considered a single clinical entity. Authors have not agreed on a uniform title. The term epidemic jaundice is not justified as many cases are mild and never develop icterus. Epidemic hepatitis is a term first suggested by Meulengracht to describe more accurately the condition previously referred to by Virchow as acute catarrhal jaundice. But since the disease has been shown to be caused by an infectious agent and since it occurs sporadically in civilian life and not always in epidemic form, the term acute infectious hepatitis appears more descriptive.

In civilian life this disease has been described as a disease of childhood. In wartime, however, like other childhood infections, it becomes predominantly a disease of young male adults. There have been numerous reports during the past eighteen months of the occurrence of this disease in epidemic form in the armies and navies of warring nations. During the Civil War there were 22,569 cases with 161 deaths, in a total of over 2,000,000 troops. In the Boer War there were 5,649 cases. It is known to have occurred as early as the War of 1812. Epidemics were reported in both the Spanish-American War and World War I.

ETIOLOGY AND TRANSMISSION

It is generally agreed that the causative factor in this condition is a filtrable virus. The German workers Liede and Lutz[6] reported culturing a filtrable virus on the chick embryo which they considered the probably causative agent of infectious hepatitis. This work has not been substantiated by other investigators.

During 1942, 14.7 per cent of the persons vaccinated on the Islands of St. Thomas and St. John developed hepatitis, following inoculation with a specific lot of pooled (yellow fever vaccine) serum. Oliphant and coworkers[11] using the same serum were able to produce hepatitis in 24 per cent of volunteers. In a significant number of cases they also transmitted this disease from one of these patients to another group of volunteers. They found that the hepatitis-producing factor in the vaccine was filtrable, resisted storage in wet serum for long periods at 4 C., and was resistant to heat in the dried state at 56 C. for thirty minutes. It was inactivated by ultraviolet irradiation. Havens and others[6] showed this hepatitis-producing factor is transmitted by the sera, whether inoculated subcutaneously, intravenously, or intramuscularly; also intranasally and orally. They further showed that extracts obtained from urine and stools when given orally produced the disease.

The British workers[3] have also been able to transmit the infection by giving orally ether-treated fecal suspensions obtained from patients in the early stage. Findley and Martin[4] were able to transmit the disease from nasal washings.

Neefe and others[10] were not able to transmit the disease with the excreta from cases of hepatitis of serum origin. This would indicate that the causative agent either was not present in the feces of these patients or was not active when administered by the oral route. This observation offers a possible explanation for one of the puzzling differences between serum and infectious hepatitis, namely, that no epidemics have been reported originating from patients contracting the disease by means of serum inoculation.

The incubation period of the different types has been variable. Generally the period required for the symptoms to develop was much greater in those receiving serum containing hepatitis-producing agents (50 to 70 days) than those receiving the factor orally (20 to 22 days).

One of the most significant factors revealed in this study was that 25 per cent of the patients admitted gave a history of excessive consumption of alcoholic beverages, varying from one to several weeks previous to the onset of the initial symptom. Laboratory studies on admission revealed a reduction in the total protein with elevation of globulin at the expense of albumin in many of these cases, but because of the length of time from onset to hospitalization, it was impossible to determine if this reduction occurred before or after the disease began. The work of Miller and Whipple[8] showed that liver injury due to chloroform anesthesia increased in extent as the body stores of

From the Plains Clinic.

protein were depleted. Messinger and Hawkins[7] found that carbohydrates or protein-rich diets protected dogs' livers against injury by arsphenamine. The protective value of carbohydrates was less than protein. It has been further shown by Miller and others[8] that the sulfur-containing amino acids methionine and cystine are the specific factors for the protective action of protein. It is well known that excessive drinking results in the loss of appetite with low food consumption, which would ultimately result in a low protein reserve. There may be a direct relationship between protein metabolism and resistance in sporadic cases of infectious hepatitis. Other factors found to be predisposing to this infection were chronic illness and diarrhea.

A pathologist developed the disease forty-seven days following an autopsy on a patient who had died of infectious hepatitis. Another case was that of a dentist who had examined and treated a patient with hepatitis thirty-two days prior to the onset of his infection. His onset was of a respiratory nature, with dryness of his throat and a dry cough; that of the pathologist was gastro-intestinal, with nausea, vomiting, and anorexia. There may be some relation between the mode of entrance of the virus and the type of symptom at the onset before the disease is localized in the liver. As suggested by Barker and others[1] it is first a systemic disease.

CLINICAL PICTURE AND COURSE

This report deals specifically with 52 cases. The age distribution was between 5 and 64 years of age with an average of 25.4 years. All the patients were male with one exception. The age and sex picture is not as conclusive as it appears, inasmuch as the majority of admissions in this hospital were young male adults, but it demonstrates the fact that the disease may occur in any age group.

It is generally accepted that the annual peak of incidence in the area north of the Equator is late autumn, and the peak south of the Equator late spring. Nevertheless, this study shows no appreciable seasonal difference. December was the only month in which there was no case reported, and September was the highest with 17 per cent.

PRE-ICTERIC STAGE

There were only 2 patients in this series who reported to the hospital in the pre-icteric stage. They were suffering from a chronic disease and developed the infection while in the hospital. The chief complaint of the other patients was icterus. The average time from the onset of the initial symptoms to admission was eleven days. The shortest was one day; the longest, eighteen months. The latter occurred when a man refused to quit work for treatment and thought he could "wear it out." In general, the most constant prodromal symptom was nausea and vomiting, and over one-half complained of pain in the right upper quadrant. A small percentage (10 per cent) began with respiratory complaints. The onset of symptoms preceded the appearance of jaundice from one to eighteen days with an average of six days. The characteristic symptoms were malaise, headaches, lassitude, abdominal discomfort, and anorexia. Generalized muscle aching was a prominent feature. Because of the delay from the initial symptoms to admission, only a few patients had fever, but the vast majority gave a history of chilly sensations, accompanied by fever. Transient loose stools were frequently noted at the onset.

The conditions which are most frequently confused with hepatitis before icterus appears are: upper respiratory infection, atypical pneumonia, influenza, and infectious mononucleosis. Repeated physical examinations and laboratory studies may be necessary to make the correct diagnosis. In some cases it may be necessary to wait until evidence of liver damage appears before diagnosis can be certain. There may be a combination of hepatitis with one of these conditions as was seen in 1 case which began with a primary atypical pneumonia.

STAGE OF ICTERUS

Most of the patients were first seen in this stage. One of the most important observations at this stage was right upper quadrant pain associated with localized tenderness, which at times simulated an acute abdominal condition. An enlarged and tender liver which was almost invariably present tended to confirm the diagnosis.

This period of rising icterus was remarkable in that the patients were relatively symptom-free. Clay-colored stools were noted in about half. Pruritis was infrequent. Characteristically, the maximum elevation of icterus was reached from two to fifteen days with an average of one week. The defervescent period began shortly after the maximum icteric level was reached. The duration of this period was variable, the most important features being the time that had elapsed before institutional therapy, the height of the icterus, and the type of treatment employed. The average duration of jaundice was between two and eight weeks with an average of five weeks. This index provides in a general way the index to the rate of recovery. Of interest is the fact that the pa-

tient who gave a history of the disease for eighteen months required the longest period of hospitalization, four months. Fat intolerance was the most constant symptom during this period. The stage of recovery was relatively uneventful with prompt disappearance of the physical symptoms well in advance of the jaundice.

In the icteric phase care must be observed to rule out all other causes of jaundice. The most important of these is Weil's disease, amebic hepatitis, malaria hepatitis, hemolytic jaundice, and obstructive lesions of the biliary tract. Homologous serum jaundice and arsenical hepatitis are very similar and cannot be differentiated either clinically or pathologically from acute infectious hepatitis.

LABORATORY STUDIES

The laboratory observations were variable in the early stages of the disease. One of the most constant findings was a mild leukopenia, usually associated with a relative lymphocytosis. The lymphocytosis was atypical and similar to that of infectious mononucleosis.[9] The urinalysis was uniformly normal except that urobilinogen was often absent in the period of rising icterus, but then appeared in abnormal amounts. In the icterus stage, which is characterized by an increase in serum bilirubin, the degree of icterus was a variable factor, ranging from 8 units to 110 units, with an average of 37.4 units. The period of regression to normal varied from two weeks to four months, with an average of five and a half weeks. This period of regression seemed to be related to the lapse of time from initial symptoms until the institution of therapeutic measures. There was almost a universal reduction in serum albumin with increased serum globulin; also 22 per cent had a reduction in total protein.

Various laboratory procedures and tests of liver function are useful in the diagnosis of hepatic disease and the evaluation of the degree of hepatic dysfunction. The bromsulfalein, galactose tolerance, and Hanger's cephalin flocculation tests[4] were used in this series. The results were not generally uniform, but it may be said that clinically these tests, which are designed to measure the ability of the liver to perform certain of its chemicophysiological functions, reveal varying degrees of impairment.

PATHOLOGIC STUDIES

The opportunity was afforded to observe, in the same patient, the liver in two pathologic stages, the acute and also the subsiding, at which time biopsy specimens were removed for study. The first examination revealed a small firm liver with an indurated surface. There was no evidence of inflammation of the common duct nor of the hepatic ducts, nor was there any evidence of lymphadenopathy. The gallbladder was also normal. A biopsy at this time showed a histological picture of granular and hyaline degeneration of the parenchymal cells within the liver lobule. There were a few polymorphonuclears, leukocytes, and monocytes in the periportal areas. Three months later another laparotomy was performed, and at this time the gross picture was very similar to the previous one, and the biopsy showed regenerative changes taking place within the liver lobule.

TREATMENT

In patients with acute infectious hepatitis, optimum care and treatment of the patient depends largely upon the early recognition of the condition with prompt hospitalization. Nutrition and fluid balance should be maintained during the acute phase, and as soon as the patient is able to retain it he should be provided with an adequate diet. Special emphasis should be made upon restriction of activity during convalescence.

In the acute phase the patient should be kept strictly in bed with maintenance of nutrition and fluid balance, especially if vomiting is severe and intractible. This may be carried out by means of frequent infusions with glucose and protein hydrolysate (Amigen*). Limitation of fat in the diet is desirable, although its complete elimination detracts greatly from the appeal of the diet to patients who require encouragement to eat. This may be overcome to some degree by the use of small amounts of cream and butter. All diets were fortified, especially with protein and carbohydrates. Vitamin supplements were used, and in 1 case in which the prothrombin time was prolonged, vitamin K was given parenterally with beneficial results. Alcoholic beverages were strictly prohibited for a period of several months after recovery.

Stokes and Neefe[12] recently reported that gamma-globulin given during the incubation period may abort or decrease the severity of the disease process. Although it was not used in this series, it would certainly seem worthy of a trial, since no other specific therapeutic measures are available.

During the period of convalescence an adequate diet was maintained. Most of the patients complained of fatigue and frequently of a heavy feeling in the right upper quadrant. No recrudescence occurred, probably because no great haste was made in

*Trade name for product of Mead Johnson & Company, Evansville, Ind.

granting privileges for activity. Resumption of full activity was allowed after physical laboratory examination revealed complete recovery of liver function. This resumption of activity was on a gradually increasing scale, allowing two to four weeks to accomplish full activity.

SUMMARY AND CONCLUSION

A series of 52 cases of acute infectious hepatitis occurring sporadically over a period of two years have been reviewed. This disease occurs endemically in civilian life. It has been shown that this disease is similar to, if not identical with, that occurring in the armed forces in epidemic form.

One of the most important factors is early recognition with prompt institution of treatment. Factors influencing the onset of this disease were found to be alcoholism, diarrhea, and chronic illness.

Dietary factors in recovery are thought to occupy a place of prime importance, especially increased protein intake.

Deleterious effect of exercise and beneficial effect of rest is a factor in the absence of relapses in this series. The disease may appear to be more serious in the armed forces than among civilians partly because of circumstances of combat duty, but it is also the result of a failure to recognize the clinical picture of the disease and its sequelae in civilian practice.

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During the period of the war, there occurred in the United States more than two deaths from tuberculosis for every three lives lost in combat by the armed forces of the United States.—J. Yerushalmy and I. M. Moriyama, Pub. Health Rep., Apr. 5, 1946.

WAR WOUNDS OF THE LIVER

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The war recently ended afforded an opportunity for the critical appraisal of the surgical treatment of liver wounds. In discussions based on World War I experience, hemorrhage from liver wounds usually was considered as the chief cause of fatalities and complications.[1, 3, 4] Our observations as medical officers in the Army in World War II, however, pointed to the complications of bile leakage and hepatic parenchymal damage as of greater significance. These observations led us to alter our mode of surgical care, as will be described. A significant reduction in mortality rates compared with World War I figures was obtained (table 2) despite evidence that wounds encountered by us in World War II often were more serious, involving other abdominal viscera more frequently. We feel that improved surgical handling should receive a major share of the credit.

In the Mediterranean and Southern European campaigns of World War II, a large percentage of the battle casualties sustaining liver wounds were given initial surgical care in field hospitals or other forward hospitals by auxiliary surgical teams. Because of this circumstance it is felt that the collected experiences of the Second Auxiliary Surgical Group with wounds of the liver for the period January 1, 1944, through May 8, 1945, warrant careful analysis.

The data presented are based on a series of 829 patients with wounds of the liver, taken from a group of 3,154 abdominal and thoraco-abdominal cases for the above period. There were 3,066 records sufficiently complete for our analysis. The data apply necessarily only to the course in the forward hospitals where initial surgery was performed. Sufficient information pertaining to the subsequent histories of these patients in hospitals to the rear is not available for analysis at this time. Some of the clinical records were incomplete in various details. Certain charts and tables have been based, therefore, on less than the total cases studied.

INCIDENCE

Table 1 presents the over-all incidence (and mortality) for wounds of the liver and biliary tract in our series, 1944 and 1945.

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*Formerly members of the Second Auxiliary Surgical Group, Medical Corps, U. S. Army.

Read before the Section on Surgery, State Medical Association of Texas, Annual Session, Galveston, May 7, 1946.

The route of injury was abdominal in 46.2 per cent of these liver wounds and thoraco-abdominal in 53.8 per cent. Furthermore, 59.2 per cent of liver wounds were complicated by coincidental wounds of other abdominal viscera.

It is interesting to compare the incidence of liver wounds in this series with available statistics for World War I (table 2). Restricted to liver involvement in abdominal wounds only, the World War I incidences of

TABLE 1.—*Incidence and Mortality of Wounds of Liver and Biliary Tract.*

	Jan. 1-May 8, 1944	1945	Total
Total Cases Abdominal and Thoraco-Abdominal Wounds	2,383	771	3,154
Total Cases Utilized	2,295	771	3,066
Total Cases, Wounds of Liver	646	183	829
Incidence, Wounds of Liver	28.1%	21.3%	26.7%
Fatal Cases, Total	193	31	224
Mortality Rate, Total	29.8%	16.9%	27.0%
Wounds of Gallbladder and Bile Ducts (liver involved in all cases)			
Number of cases	40	15	53
Percentage of All Liver Wounds	1.7%	1.7%	1.7%

13.3 per cent and 16.8 per cent, respectively, are seen to agree fairly closely with our incidence of 17.1 per cent.

TABLE 2.—*Wounds of Liver: Comparative Statistics from Two Wars.*
(Abdominal Wounds Only.)

	World War I Surg. Gen. Reports[3]	Wallace British[5]	World War 11 2nd Aux. Surg. Grp. 1944	1945	Total
Percentage of Abdominal Wounds with Liver Involved	13.3%	16.8%	18.5%	12.6%	17.1%
Operative Mortality of Liver Wounds	66.2%	.....	34.0%	15.1%	27.9%

Comment: Although the incidence of liver involvement in abdominal wounds for two wars was quite similar, there has been a sharp drop in operative mortality rates in World War II. This comparison is only approximate since the World War I figures may not include some liver wound cases treated without operation.

MORTALITY

The over-all mortality rate for wounds of the liver in our series was 27.0 per cent as contrasted to a mortality rate of 66.2 per cent in World War I (table 2).

The number of viscera involved in association with the liver wound represented the most important single factor in prognosis. As shown in table 3, mortality was directly proportional to the number of other viscera wounded. Uncomplicated wounds of the liver had a mortality rate of 9.7 per cent. The mortality rate when the liver and one other organ were injured was 26.5 per cent. But the mortality rate rose to 84.6 per cent when the liver and four or more other viscera were wounded.

From table 4 it will be seen also that when the liver was injured in association with the colon only, the mortality rate was the greatest for any single organ-liver combination (32.3 per cent). The second most serious combination was that in which the liver and the stomach-duodenum were involved. (31.3 per cent.)

TABLE 3.—*Multiple Organ Involvement Effect on Mortality Rate of Liver Wounds.*

	1944	1945	Total
Total Liver Wound Cases	646	183	829
Mortality Rates:			
Over-all mortality	29.8%	16.9%	27.0%
Liver (uncomplicated)*	9.8%	9.5%	9.7%
Liver plus other abdominal organs (combined)	42.7%	23.0%	38.5%
Liver plus 1 other organ	29.1%	15.2%	26.5%
Liver plus 2 other organs	43.9%	25.7%	39.7%
Liver plus 3 other organs	60.0%	33.3%	54.8%
Liver plus 4 or more other organs	90.9%	50.0%	84.6%

*Liver wounds uncomplicated by wounds of other abdominal viscera. Coincidental wounds of other portions of the body may be present in such cases.

TABLE 4.—*Effect of Injury to Certain Other Abdominal Organs on Mortality of Liver Wounds, 1944-1945.*

Name of Viscera	No. Cases	Deaths	Mortality Rate %
Liver only	339	33	9.7
Liver plus stomach-duodenum	64	20	31.3
Liver plus jejunum-ileum	15	2	13.3
Liver plus colon	34	11	32.3
Liver plus kidney	77	20	25.9

OTHER FACTORS AFFECTING MORTALITY AND MORBIDITY

The location of the wound is important because of the proximity of other organs. Wounds about the hilum of the liver occasionally involved the extrahepatic biliary ducts, retroperitoneal duodenum, pancreas, stomach, colon, or vena cava. These complicated wounds carried a high mortality rate. During the year 1944, 538 records defined the location of liver wounds with sufficient accuracy for use in this study (table 5).

TABLE 5.—*Anatomical Site of Liver Wounds in 538 Cases.*

Lobe of Liver Involved	No. Cases	Percentage
Right	446	83.5
Left	73	13.1
Both	19	3.4

The extent and location of the liver wounds are of importance. However, a small penetrating wound may be followed by more serious complications, such as bile leakage or hemorrhage, than one in which a larger mass of liver tissue is involved. The majority of wounds in this series, 76 per cent, were small or moderate in size. They were described usually as lacerated, penetrating, or perforating wounds, moderate in degree. Twenty-four per cent of the group were described as "severe" wounds. The loss of liver tissue including that removed by debridement occasionally amounted to a substantial part of a lobe, rarely even the entire left lobe. Bleeding from the liver had ceased at the time of exploration (which averaged 11.3 hours after wounding) in 91.1 per cent

of the cases. In the remainder it was rarely described as severe. In no case of this series was death ascribed to bleeding from the liver during the postoperative period in the forward hospitals. It was impossible to measure the amount of bile in the peritoneal cavity. Usually some bile leakage had occurred, but the presence of much intestinal content plus exudate and blood made even a rough estimate unsatisfactory.

There are certain associated factors which may have influenced the morbidity and mortality in this group although difficult to prove statistically. The wounding agent, the time lag from injury to surgery, adequate treatment of shock, and the use of sulfonamides and penicillin all played varying roles. It is known also that the mortality in this group of cases was higher in winter months when evacuation was delayed and the incidence of pulmonary infections more prevalent.

OPERATIVE INCISIONS

Location of operative incisions in these liver wound cases for the 1944-1945 period was as follows: abdominal 47.2 per cent, thoracic 38.3 per cent, both 12.5 per cent. The incision frequently varied with the amount of visceral injury in any given case and in particular whether thoracic or abdominal viscera or both were involved. There was an increase in the transdiaphragmatic approach for the 1945 group of 14.1 per cent over the 1944 group. With increased experience the surgeons found the results to be better when this approach could be utilized. Thoracolaparotomy was performed in 7 cases. If, in this incision, the thoracic wound is extended down over the anterior chest wall into the abdomen, cutting the costal arch in its course, complications may follow. Such wounds become infected easily and tend to break down, resulting in difficult treatment problems. If the abdominal pathologic conditions encountered in a thoraco-abdominal wound cannot be handled adequately through the initial thoracic approach, we believe a separate laparotomy incision should be used rather than cutting across the costal arch.

SURGICAL TREATMENT

A tabulation was made of the various types of surgical treatment of the liver wound itself (table 6). Of all 695 cases tabulated 57.8 per cent were treated by placement of drains only, 28.2 per cent by packing, 5.3 per cent by suture of the wound plus drainage, and 7.8 per cent without local treatment. Of more significance, however, is the change in these modes of treatment with increased surgical experience. The use of drains only rose from 48.5 per cent in 1944 to 87.4 per cent in 1945, with a corresponding reduction in use of the liver pack from 34.1 to 9.6 per cent. There was also a sharp decrease in the number of liver wounds left without any treatment in 1945 though the total number of such cases was small. The trend away from packs to external drainage alone in our later experience paralleled the marked drop in mortality rate in 1945 (see table 1).

TABLE 6.—*Types of Surgical Treatment.*

	1944	1945	Total
Total cases tabulated	528	167	695
Type of treatment:			
Drain(s)	48.5%	87.4%	57.8%
Pack	34.1%	9.6%	28.2%
Suture and drain	6.5%	1.8% (3 cases)	5.3%
Suture and pack	0.95% (5 cases)	0%	.....
Muscle graft	0.15% (1 case)	0%	.....
No treatment	9.8%	1.2% (2 cases)	7.8%

TABLE 7.—*Principal Causes of Death.*
Total deaths, 224. Mortality rate, 27.0%.

	1944 %	1945 %	Total %
Shock	51.8	48.4	51.4
Pulmonary complications	17.7	12.9	17.0
Peritonitis	12.9	9.7	12.7
Renal failure	8.3	9.7	8.5
Other causes	9.3	19.3	10.7

Comment: Persistent shock was responsible for approximately half the deaths despite vigorous anti-shock treatment combined with early operation and a minimum of transportation of the patient.

Table 7 enumerates the principal causes of death. Autopsies were performed on a majority of the patients who died in the forward hospitals. This was done most frequently by the operating surgeon himself. Shock was listed as the chief cause of death in 51.4 per cent (115 cases). This diagnosis represented a state of persistent circulatory collapse despite all efforts to combat it, and none of the patients so listed survived beyond the second postoperative day. Blood loss appeared to be only one of several factors contributing to the shock. A multiplicity of factors including disturbances of cardiorespiratory physiology, overwhelming contamination of the peritoneal and pleural cavities, tissue destruction, and widespread retroperitoneal cellulitis all played significant roles.

Pulmonary complications represented the second most important group of causes of death. There were 38 such cases, 17 per cent of the total group of fatalities. Trauma to the diaphragm in over half of the liver wounds, trauma to the lung, bile contamination of pleural cavities, and prolonged ether anesthesia provided ample background for pulmonary complications.

Some degree of peritonitis existed in all

the fatal cases. When listed as a cause of death, it implied either a widespread or marked local process (such as subphrenic abscess).

Oliguria and renal failure represented the chief cause of death in 19 cases (8.5 per cent). It is interesting to speculate on the possible relationship of liver damage to renal failure though we could not eliminate transfusion or "shock kidney" as the basic pathologic condition in most of these cases.

A miscellaneous group of causes of death, gas gangrene, head injury, paralysis following wounds of spinal cord, and others, totaled 10.7 per cent (24 cases).

EXTRA-ABDOMINAL WOUNDS

Coincidental wounds outside of the abdominal cavity undoubtedly exerted an effect on morbidity and mortality in this series. These included frequent injury to the lung, occasional trauma to the heart, and, in every thoraco-abdominal case, wounds of the chest wall and diaphragm. Several instances of spinal cord wounds contributed to mortality also. The significance of peripheral wounds such as compound fractures of long bones, traumatic amputations, or head wounds could not be evaluated separately.

WOUNDS OF THE GALLBLADDER AND BILE DUCTS

Fifty-three wounds of the gallbladder and bile ducts (51 gallbladders, 2 common ducts) were included in this series and represented 6.3 per cent of total liver and biliary system or 1.7 per cent of all abdominal and thoraco-abdominal wounds. In every case, the gallbladder or bile duct wound was complicated by a wound of the liver. Because of this circumstance and the frequent occurrence of wounds of other abdominal viscera in these cases, it was impossible to evaluate their significance in the morbidity and mortality rates. In general, however, the mortality for cases exhibiting wounds of the gallbladder and bile ducts has been 30 per cent, corresponding closely to the over-all mortality rate of 27.0 per cent in liver wounds. The degree of damage to the gallbladder varied greatly. In 1 case, the fundus was partly avulsed from its bed without direct damage to the gallbladder wall. Simple suture sufficed to repair this damage. In 5 instances small wounds of the fundus were closed with purse string sutures. The balance of 47 cases was about equally divided into severely lacerated gallbladders requiring cholecystectomy and less severe wounds treated by tube cholecystostomy. One of the 2 common duct patients sustained a wound of the duct near the ampulla of Vater. This was overlooked at operation and undoubtedly contributed to the death in this case. In the other case the common duct was perforated in the hepatico-duodenal ligament. Simple suture without drainage was followed by recovery.

DISCUSSION

The large number of liver wounds encountered in this war and the frequency of complications following some methods of treatment have directed our attention to a more critical appraisal of the important problems. In the past, the chief concern in the treatment of liver wounds has been the control of hemorrhage. It is our belief, based upon this large series of cases and our own personal experiences in both forward and base hospitals, that bleeding is not the most important feature. In only 9 per cent of this large group of cases was active bleeding from the liver wounds found at the time of exploration. In 91 per cent of the cases, therefore, spontaneous hemostasis had occurred by the time of operation. Both the hepatic artery and portal vein, after entering the porta of the liver, branch rather promptly into smaller ramifications. Unless a hilar injury is sustained or a missile penetrates deeply into the liver, serious bleeding should be rare. Branches of the portal vein near the surface are larger than adjacent arteries. The pressure in the venous system is low (5-10 mm. mercury), however, and bleeding from these vessels can be controlled by temporary pressure and cigaret drainage, as will be described. In this series of liver cases only one instance of serious postoperative bleeding occurred.

It is our opinion that the establishment of adequate external drainage of both bile and products of tissue injury is the most important feature in the surgical care of liver wounds. Any method that will satisfactorily accomplish this should be followed by good results. The dry pack, so generally advocated in the literature for its hemostatic value, will not function as a drain.

Suture of liver wounds and the occasional use of a muscle graft have been advocated by some surgeons. It has been our observation, as well as that of others, however, that the bleeding caused by placement of sutures in an attempt to close a wound of the liver may exceed that which existed previously. A temporary pack, however, may be effective in checking bleeding during the operation. For example, in 1 case active oozing from a large superficial wound of the right lobe of the liver was observed at the time of operation. Dry gauze was packed against the bleeding area until the remainder of the abdominal pathologic damage was cared for.

Before closing the abdomen, the pack was removed and it was found that all the bleeding had ceased.

The number of complications of liver wounds seen in field hospitals is small when compared with those in hospitals further to the rear. A report[2] from a chest center at a general hospital offers a better indication of the frequency of these complications. In a series of 98 wounds of the liver which had received their primary operative treatment at forward hospitals, Burford found that 25 per cent presented complications. These were complications resulting from inadequate drainage and included 14 cases of subphrenic abscess, 5 cases of bile empyema, and 6 cases of intrahepatic abscesses.

A gauze pack does not function as an adequate drain. The pack, whether used alone or in conjunction with drains, tends to act as a tampon, causing pocketing of bile and exudates and formation of the complications mentioned above.

The diaphragm was perforated, of course, in all the thoraco-abdominal wounds (53.8 per cent of all the wounds in our series). The bile and exuded fluids, prevented from draining externally by the liver pack have, on occasions, forced their way through the sutured diaphragmatic wound. This has been followed by a bile empyema or biliary thoracic fistula. This complication was seen in different cases regardless of the type of closure of the diaphragm. In one instance, the lung was adherent to the suture line of the diaphragm and the bile eroded through into a bronchus. Occasionally, the bile not only eroded the sutured diaphragm, but, after reaching the pleural cavity, produced also a breakdown of the thoracotomy incision. Subphrenic pleurocutaneous-fistulas resulted. Intrahepatic necrosis, abscess, hepatitis, and bile peritonitis have all been observed in cases treated with gauze packs. A less important but significant feature is the pain associated with the removal of a large liver pack. It occasionally necessitated the use of an anesthetic, thus adding to the postoperative problem.

Secondary hemorrhage following the removal of a pack may occur. One of us (G. F. M.) observed an autopsy on a patient who sustained a fatal secondary hemorrhage following the removal of a liver pack on the eighteenth postoperative day at a general hospital. Vascular granulation tissue had grown into the meshes of the gauze and bled profusely when the pack was torn loose. The patient became exsanguinated before surgical intervention could be undertaken.

In an effort to avoid such bleeding, very early removal of the pack has been practiced in some cases with resultant premature closure of the external drainage wound. Once such a pack has been removed, it is nearly impossible to reinsert an adequate drain down to the wound site and pocketing of bile and exudate is likely to result.

For the various reasons stated above, we feel that packs should not be left in liver wounds.

The placing of the wick end of a Penrose cigaret drain to act as a clot supporting surface against a liver wound which is still oozing a little should control the situation. This also provides drainage. If large or separate wounds are present, at least two drains should be inserted down to these wounds and additional drains lateral to the liver and to the subhepatic spaces to prevent pooling of bile and exudates in these regions. All drains are delivered through a dependent drainage incision, usually placed subcostally, in the anterior or midaxillary line. This drainage incision must be at least 1.5 inches in length and cleanly incised through all layers of the abdominal wall to avoid constriction of the drains. The drains should not be brought to the exterior through the laparotomy or thoracotomy incision, since this leads to a higher incidence of wound infections and disruptions. A debrided wound tract coinciding with the usual subcostal drainage incision location may be satisfactory.

The proper removal of the drains holds as important a place in the treatment of the liver wounds as does their initial placing. The shortening must be gradual, beginning usually on the fourth and fifth postoperative day. The drains are out completely, preferably, by the tenth to twelfth postoperative day, though complete removal should be deferred until drainage has virtually ceased. Frequently such a staged removal of Penrose cigaret drains become difficult because of the adherence of the gauze wick to the liver bed. Because the free outer ends will stretch before the inner ends are moved, the sudden "give" following traction or twisting of the drains may withdraw the drains too far; fluid collections are thus likely to become pocketed in the liver region. To avoid such a possibility we use drains in which the tendency to stretch has been eliminated. This is done by simply threading surgical tape through the Penrose tubing and anchoring the tubing to it, at intervals of 3 to 4 inches, by means of silk suture. Thus when one withdraws the free outer end of the drain an inch, the inner end is withdrawn a like distance.

Rarely is a liver wound too small to be drained. It is true that some cases will not

drain bile postoperatively, but we know of no criteria by which such cases can be selected preoperatively or at operation. The size of the missile is not the all important factor. A small foreign body which cuts a main bile passage may be followed by a greater drainage of bile than a superficial liver wound of greater proportions. For this reason, we feel that all suspected liver wounds should be explored and adequate external drainage established.

SUMMARY

1. A large series of wounds of the liver representing the collective operative experience of the Second Auxiliary Surgical Group, for the period January 1, 1944, to May 8, 1945, has been studied.

2. In a grand total of 3,154 abdominal and thoraco-abdominal wound cases (3,066 records adequate for this study), 829, or 26.7 per cent manifested wounds of the liver. The derived data apply only to the period of stay in the forward hospitals where the operation was performed. These liver wounds were found divided almost equally into the abdominal and thoraco-abdominal wound categories.

3. Over-all mortality rate for wounds of the liver in this series was 27.0 per cent (table 1). Coincidental wounding of other abdominal viscera was found to be a highly important factor in prognosis. The mortality rate for wounds of the liver in absence of other abdominal visceral injury was only 9.7 per cent in contrast to a rate of 84.6 per cent when four or more other abdominal viscera had been wounded also (table 3).

4. This study and our personal experience indicate that continued bleeding from liver wounds following operation has not been a potent cause of morbidity and mortality. Bile leakage and liver parenchymal damage appear to have been factors of greater importance.

5. The traditional pack for liver wounds has been unnecessary in most cases. Its use led to serious complications.

6. Operative exploration of virtually all liver wounds with establishment of adequate external drainage is advocated as the most satisfactory mode of treatment.

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ABSTRACT OF DISCUSSIONS

Dr. Andrew B. Small, Dallas: Dr. Madding's figures on the route of injury are interesting in that they occur almost 50 per cent through the abdomen and by thoraco-abdominal route. This makes it imperative for surgeons to consider lacerations of the diaphragm in any wounds in the mid portion of the body.

Another point emphasized is that the principal cause of death is still shock. The time interval between injury and operation is not as important as the degree of shock. Dr. Madding shows a number of deaths attributed to "shock kidney." This is the result of the profound state of shock or hypotension even in the face of adequate blood replacement. These patients live four to six days and die with anuria and uremia. Autopsy shows parenchymatous degeneration of the tubular epithelium.

Packing of liver wounds is a procedure to be avoided. Except for the immediate arrest of hemorrhage, packs should not be used. Occasionally, suturing of the liver wound gives good results but by far the desired results are obtained by adequate external drainage. External drainage provides for escape of accumulated blood and bile and will prevent the serious sequelae of liver abscess and/or bile pleuritis.

When liver injuries also lacerate the diaphragm, the latter structure must be sutured. With minor chest injuries which can be treated conservatively, the diaphragm may be sutured through the abdominal approach at the same time external drainage is established. Certain parts of the diaphragm are not accessible through the abdomen and a thoracotomy must be done.

Dr. Donald L. Paulson, Dallas: Dr. Madding has presented an unusual series of wounds of the liver. I should like to call attention to bile pleuritis which may complicate a liver wound. If the subphrenic space is not drained at the time of the repair of the lacerated diaphragm, bile may break down the repair and drain into the pleural cavity through the diaphragm, resulting in a bile pleuritis. A bile pleuritis is usually sterile because bacteria do not grow well in the presence of bile. The treatment of a bile pleuritis should consist of a modified open drainage of the pleural cavity until the drainage of bile has ceased. At the same time, any subphrenic collection should be drained. Wide open drainage of the pleural cavity in the presence of a bile pleuritis is unnecessary and may lead to a long period of pulmonary invalidism. Later, after bile drainage has ceased, negative pressure drainage of the pleural cavity may be instituted, but a decortication may be necessary if the lung does not expand completely.

Dr. John M. Thiel, Galveston: I would like to ask Dr. Madding whether or not in that small percentage of cases of liver wounds still showing active bleeding at the time of operation, he had the occasion to use fibrin foam. During the past year or more we have used it on occasions in the operating room of the John Sealy Hospital for the control of bleeding from various sources and have found it to be quite effective.

Dr. Madding, closing: I would like to thank those who discussed this paper. In answer to Dr. Thiel, fibrin foam was not available for our use in the treatment of these cases. I should again like to emphasize that the control of bleeding in liver wounds is not the important factor in their care, but establishment of adequate external drainage of accumulated blood and bile and the products of liver destruction.

TREATMENT OF COMPOUND FRACTURES OF THE LONG BONES

HOWARD DUDGEON, JR., M. D., F. A. C. S.
WACO, TEXAS

This paper will deal with compound fractures of the femur, humerus, tibia, and fibula; their immediate treatment, including that of shock and debridement of the wound; type of immobilization; and length of treatment. Unfortunately the roentgenograms of this series were lost or ruined when I was returning from overseas.

For the past four to five years a large percentage of the long bones injuries were due to gunshot wounds and were dealt with in Army hospitals. With peace here and the relaxing of gasoline rationing the automobile is again the chief source of supply of patients. These injuries may incapacitate, even without complications, for from six to twelve months, depending on the bone involved. Even with the best of professional attention they may result in permanent disability. In civilian practice all age groups are represented.

Poor or indifferent treatment usually results in either death or permanent disability, often associated with a rather active and painful osteomyelitis.

INITIAL TREATMENT

Treatment received in the first eight to ten hours usually determines the end result. Shock should be combated with morphine and plenty of plasma and whole blood. This war has demonstrated without question that many who previously would have died of shock or infection were saved by blood and plasma. The wound should be carefully cleaned with soap, water, and saline. The ragged edges should be carefully debrided, removing all devitalized tissue, foreign material, and pieces of bone which are not attached to muscle or periosteum.

The Army would not permit compound fractures to be closed, but required that they be left wide open. This was done because these patients often were not treated within the safe period of eight to twelve hours, and also because these patients often had to be evacuated immediately and could not be closely watched. In civilian practice, I think that if a wound is treated within eight to twelve hours of injury, it may be loosely closed with interrupted sutures and carefully watched. All patients should be given tetanus and gas antitoxin and immediately started on penicillin therapy, 20,000 units each three hours, and sulfadiazine, 1 Gm. with 10 gr. of soda bicarbonate each four hours. The soda is to keep the urine alkaline and prevent kidney complications.

Immediate treatment of these fractures is as important as in acute appendicitis, ruptured peptic ulcer, or ruptured extra-uterine pregnancy. This should always be borne in mind so that the job of handling compound fractures will not be assigned to some untrained intern.

If there are complicating nerve injuries the nerve should be rejoined if it can be done without unduly prolonging the operation. If this cannot be done, tantalum sutures should be placed loosely through the nerve ends so that they may be more easily located at secondary repair.

Treatment of the individual bones will be taken up separately as each one presents a problem of its own because of location and muscle attachments.

FEMUR

The femur is the largest and longest bone of the body and bears the weight of the trunk. A comminuted or displaced fracture either simple or compound will disable a patient for from eight to twelve months even with the best of care and no complications.

After initial immediate care these patients should be put up in skeleton traction in either balanced traction using half ring Thomas splint with Pierson knee piece or an adjustable Bohler thigh splint. The Kirschner wire is preferred for skeletal traction as it makes a smaller hole than other types of wires and pins. It may be put through the condyles of the femur if the fracture is in the proximal two-thirds of the bone or in the crest of the tibia at the level of the tibial tubercle if the fracture is in the distal one-third of the bone. Some surgeons prefer to put all wires through the crest of the tibia because this can be done under a local anesthetic. Most cases of simple fractures of the femur which are comminuted or displaced should be treated as above in regard to skeletal traction.

Weight put on for traction is roughly one-seventh of the patient's body weight plus ten pounds for reduction. After reduction is secured the extra ten pounds is removed.

Skin traction is not suitable because it will not support sufficient weight and it causes skin irritation. It also cannot be used where there is extensive skin and soft tissue damage or associated burns.

These patients should be kept in skeletal traction for six to eight weeks at least and then put in a hip spica cast until sufficient callus has formed, usually another six to eight weeks, but which in severe comminu-

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tion may require several months or may end in nonunion and require graft. After the cast is removed many patients must be supported for four to six months in braces to prevent refracture. I have seen this occur in several instances.

Of course, some fractures may be in good condition and can be treated with a plate, Carrell-Girard removable pin, or some other form of internal fixation. However, the less permanent hardware left or put in potentially dirty wounds of the femur the better the end result.

TIBIA AND FIBULA

As the tibia is immediately subcutaneous there are many compound fractures of this bone. The fibula is often not injured. If there is no displacement of the tibia, only a complete cleaning with soap and water and debridement is indicated. The wound should be loosely closed and a cast applied.

If the fracture is displaced and oblique or unstable, this is a good place to use a Carrell-Girard removable screw. The advantage of this pin is that at the first sign of infection it may be unscrewed and removed, thus removing all foreign material from the wound and bone. The handle of the screw protrudes from the skin and may be included in the plaster. No anesthetic or hospitalization is required for the removal of these pins.

If a removable pin is not used, a plate or regular bone screws may be employed in these oblique or unstable fractures. Internal fixation is not used on the fibula, which is reduced as well as possible and the reduced tibia depended on for splinting.

After internal fixation is applied, a thigh length cast with 10 to 15 degrees flexion of knee and ankle at 90 to 95 degrees is put on. The thigh length cast is worn for at least two months and longer if x-ray studies show insufficient callus. Removable screws should be removed in four to six weeks. After the thigh length cast is removed, a knee length one should be applied for six to eight weeks with a walking caliper. If sufficient callus is present, weight bearing may be permitted with a knee length drop foot caliper, using cane or crutches for added support. The total period of disability is usually estimated to last five to six months.

HUMERUS

There are several methods of handling fractures of the humerus depending on amount of soft tissue damage. They are (1) hanging cast, (2) shoulder spica, and (3) skeletal traction. Each will be considered separately.

1. Fractures having a minimum of soft tissue damage may be treated with a hanging cast provided the patient can sleep in a semi-reclining or even full sitting position so that he does not rest the elbow on anything and displace the fracture. This is also very satisfactory in all cases of simple humeral fractures involving proximal two-thirds of the bone. In the Southwestern Pacific Area medical officers were not permitted to transport patients for long distances with hanging casts because most patients were transported reclining. However, this method may be used very satisfactorily in civilian practice. Using this method motion of the shoulder may be started earlier and there is less prolonged disability of the shoulder motion. I adopted hanging casts with some misgivings because they violated the basic principle of immobilizing a fracture by including the joint above and below the break, but I have been pleased and I know that the patients have because they do not have to wear a heavy shoulder cast.

2. In those fractures with extensive soft tissue damage requiring frequent attention, the best method is unilateral or bilateral shoulder spica with a window cut in the cast over the wound. The wound should be dressed or disturbed as infrequently as possible. The pain from extensive soft tissue damage in itself will often prevent use of a hanging cast because of pain from motion. If there is comminution or overlapping, extension may be secured by incorporation of a Hoke traction apparatus in the spica with a Kirschner wire through the olecranon attached. Any degree of extension may be applied by this method.

3. Some badly comminuted cases may be treated by skeletal traction through the olecranon using a Balkan frame on the bed and balanced traction. The disadvantage of this method is that the patient is confined to the bed.

OPEN REDUCTION WITH GRAFTING

Some cases of open reduction develop nonunion and require bone grafts. The distal half of the humerus and tibia are common sites of nonunion. The best type of graft is a combination onlay and inlay graft. Details of graft will not be discussed in this paper.

EXTERNAL SKELETAL TRACTION

External skeletal traction on the order of the Stader or Roger Anderson splints was not looked upon with favor by the Surgeon General and was, therefore, used only occasionally by the Army Medical Corps. It certainly should not be used routinely in compound fractures, but it is of definite

value in certain types of cases. An example is that of a young officer who had a compounded femur and extensive gluteal and rectal wounds with fecal incontinence. It was impossible to put him in fixed traction because of the soft tissue wounds, so external skeletal traction was used with excellent results. I have not used it in burn cases with complicating fractures but I am sure it would be of value.

However, for results in routine use, I should like to refer to the article in *Annals of Surgery*, December, 1944, by Irwin E. Siris, M. D., on 80 cases taken from the Surgical Service of Bellevue Hospital, New York. Siris reported there was discharge from pin sites in 46 per cent; osteomyelitis of the pin sites with persistence of discharge long after the fracture had united in 22.5 per cent; and death in 10 per cent. He believed that too much emphasis has been laid on early ambulation and joint motion. It should be pointed out again that there is still no quick and magic method that will make fractures heal quickly.

SUMMARY

It has been pointed out that compound fractures of the femur, humerus, and tibia are disabling fractures which require careful cleaning and debridement followed by large amounts of penicillin and sulfa drugs. It is believed that fractures of the femur are best treated by preliminary skeletal traction with later use of hip spicas or some type of ambulatory brace. The tibia may be treated by removable pins or plates or bone screws, depending on the type of fracture, and then immobilized in thigh length plaster. The humerus may be treated with hanging casts, shoulder spicas, or skeletal traction. External skeletal traction should be reserved for special cases and should not be used routinely.

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Professional Building.

Tuberculosis is the most virulent scourge in Greece today with malaria a runner-up. Entire villages in which every citizen seemed to be suffering from tuberculosis were seen. Although there is less starvation, disease is widespread because many persons are still crowded together in dugouts, basements, and lean-tos. Through joint efforts of the government and relief associations, vitamin foods are being served daily to thousands of child war victims.—John Dula, Senior Child Welfare Specialist of the UNRRA. J. A. M. A., Jan. 12, 1946.

THE USE OF THROMBOPLASTIN FIXATION IN SKIN GRAFTING AND WOUND HEALING

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Thromboplastin fixation is, as the name implies, a fixing of the wound edges together, or in the case of a skin graft, the fixing of the graft to its bed by the use of thrombin and plasma under optimum conditions. It is a relatively new technique that may be employed in wounds of many types and has its greatest usefulness in the field of skin grafting. In the past the difficulty in obtaining proper pressure, together with infection, has been responsible for a large percentage of failures. Every conceivable type of material has been used in recent years in an effort to obtain the optimum pressure, but there is no practical way of actually measuring it after the pressure is applied, or determining an ideal amount. Fixation with thromboplastin has solved the problem of pressure, in addition to its other advantages.

PHYSIOLOGICAL CONSIDERATIONS

The principle of thromboplastin fixation was introduced only two years ago by Dr. M. E. Sano.[2] She was prompted to make her investigation after some unpleasant experience as an assistant at skin grafting procedures where excessive bleeding was encountered from the sutures. It occurred to her that the principles employed in growing cells in the laboratory in tissue cultures might be successful in skin grafting by providing the physiological adhesion of the graft to its bed through the use of thrombin and plasma.

Dr. Sano reviewed the two conditions so essential to growth in tissue cultures: first, a suitable surface for the cell to grow on through the use of coagulated plasma, and second, adequate nutrition through a medium made up of embryonic tissue extract and a buffer salt solution which she calls "Tyrode's solution"* and which consists of a number of inorganic salts, all of which are easily obtainable. Cell growth in tissue culture is facilitated by employing homologous plasma and tissue extract. Heparin or oxalate is added to the whole blood to prevent clotting until the three agents (plasma, tissue extract, and the solution of salts which supplies

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*Tyrode's solution consists of sodium chloride 8.0 Gm., potassium chloride 0.2 Gm., calcium chloride 0.2 Gm., magnesium chloride 0.1 Gm., sodium acid phosphate 0.05 Gm., sodium bicarbonate 1.0 Gm., glucose 1.0 Gm., with distilled water added to make 1,000 cc. filtered through Berkefeld filter "W."

the calcium that has been previously removed) are allowed contact at the time of planting the culture. At this instant the fibrin is precipitated and a delicate clot is formed to which the tiny fragment of tissue clings and begins its rapid cell growth.

These principles were first employed by Dr. Sano with experimental grafts on 12 rats with gratifying results and have led to extensive use of the method.

LABORATORY TECHNIQUE

The project described in this paper is based on her original technique, with slight modifications. With the excellent coöperation of the laboratory, I have evolved a standard procedure which is now employed. I am in agreement with Sano[2] and Sheehan[3] that in any actual clinical case it is more practical to use the patient's own plasma and cell extract than a stock preparation, and I also believe that this affords a better chance for success. In my cases, I have employed autogenous plasma and autogenous cell extract on every case. The latter is really a suspension of white blood cells and with Tyrode's solution it is added to the plasma; all the agents necessary to create a firm adhesive clot are present. I have made a slight change in Sano and Sheehan's technique by using oxalate instead of heparin, since oxalate works quite as well, is less expensive, is easily obtained, and makes possible autoclaving the anticoagulant in a test tube before use.

TECHNIQUE OF PREPARATION OF THROMBOPLASTIN FIXATIVE

Approximately 10 cc. of blood is withdrawn using aseptic technique and are placed in a sterilized tube containing .5 cc. of 0.9 per cent oxalate solution. The tube previously has been sterilized in the autoclave with the oxalate inside the tube and corked (Wassermann tube, 11 by 120 mm.). The cork is replaced and the blood is immediately agitated for mixing by simple inversion of the tube several times. The test tube is then placed in a centrifuge, using careful counterbalancing. It is then spun in the centrifuge at 2,000 r. p. m. for twenty minutes. Following this the plasma is withdrawn (by the use of a previously sterilized hemoglobinometer pipet which has been attached by a rubber tube to a 10 cc. syringe) and placed into another sterile test tube and corked. In a third test tube, which has been previously sterilized and which contains a few previously sterilized glass beads, 5 cc. of Tyrode's solution is placed. Then the creamy layer of white cells is scooped out aseptically using a sterile platinum loop (the loop, at its tip, has been bent to right angles with the long axis of the holder). Several dippings are necessary to accomplish the removal of the layer of white cells (one must avoid reaching too deeply so as not to agitate the tube at this time). Thus a minimum of red cells is transferred with the white cells into the Tyrode's solution. Both tubes are corked and taken to the operating room for the use of the operator. It must be pointed out that the use of the oxalate in place of previous methods simplifies and cheapens the procedure and in no way, in my opinion, is inferior to the other methods. There is sufficient calcium and other ionic salts to neutralize the anticoagulant effect of the oxalate and provide a sufficiency of calcium ion so that the normal clotting mechanism may proceed.

SURGICAL TECHNIQUE

The technique of the surgical procedure is a little different from that in the usual skin graft. To begin with, in the cutting of the graft, allowance is made for the different method of application. It has long been the practice to suture a graft in its bed under tension, and in order to do this an exact pattern of the defect to be covered was taken and the graft was cut to fit. Since the graft always shrank 20 to 30 per cent, it would necessarily be under tension, and heretofore, it was felt that was desirable and physiological. However, with the new method, the graft is made 20 per cent larger than the pattern since it is to be fitted into place without the previously mentioned tension, and this must be kept in mind.

By arrangement with the laboratory, the two solutions just described are brought to the operating room during the procedure at about the time the graft has been taken and is to be placed in its new bed. The solutions are transferred into two sterile medicine glasses from the test tubes after the latter have been flamed. They are then placed on the instrument table as part of the regular sterile equipment used in the operation. Using a light camel's hair brush, the area that is to be grafted is painted with the plasma, and the cell extract is applied to the raw surface of the graft.[1] Even though the graft is cut 20 per cent larger than the defect it shrinks considerably and must be stretched into place. At first this shrinkage prompted me to break the rules slightly and put in two or more retention sutures at one end of the graft and stretch the skin from this point to the other parts of the graft. However, it was soon found that proper stretching and pressure can be well accomplished by the use of, first, a hand roller,

and then added pressure by the use of the palm of the hand, placed against the graft for a period of two to three minutes. When the hand is removed, the graft is firmly adhered to its bed and one does not have to be too careful in handling this region after this stage of the operation. What happens is that the prothrombin in the cell extract when in contact with its plasma is converted into thrombin, and the thrombin acting upon the fibrinogen in the plasma converts it into fibrin. A fibrin matrix is thus formed which seals the graft to its bed.[2, 3] Sheehan stated that fibrinogen alone will form the required matrix that will seal the graft to its bed. He made the further observation: "the plasma alone will not promote that rapid restoration of the graft that is such a distinguishing factor in this method. The contribution of a fibrin matrix to the cultivation of living cells, which has always been recognized, is accelerated by the contact with the cell extract. This has often been demonstrated and shows the possession by the leukocytes of a function not hitherto ascribed to them and for which further research doubtless will account."[3] This marked acceleration of the entire cycle through which the graft must pass in obtaining life is the greatest contribution of this method and my observations on this phase of the subject were the principal reason for publishing this paper.

Either a very light bandage or no dressing is satisfactory. I was at first reluctant to leave off the dressing because of habit and fear, but for the past twelve months I have applied one piece of 4 by 4 inch dressing which was scarcely in contact with the graft at all, its only purpose being to protect the graft from the bed linens. These light dressings can easily be lifted for inspection of the graft.

It is well known that a skin graft goes through a very definite cycle in the process of gaining life in its new environment. At first, it is a definite white, then it assumes a mottled purplish color which becomes completely purple and deeply cyanotic. The purple later becomes mottled with slightly lighter tones, which progress until the skin becomes pink throughout. In the past, the full purple color was usually obtained on the fourth postoperative day. On the seventh and eighth days, one could note the mottled lighter tones making their appearances, with the diffuse pink coloration not becoming present until about the fifteenth day. The color changes, with their ease of observation, have proved to be one of the most interesting features of the new method and permit a very early and accurate evaluation at all times of the graft as to its viability.* In using the thromboplastin fixation the graft is a full purple at the end of forty-eight hours and one can see purplish spots in four to six hours after its application, which indicates that, though the blood is not high in oxygen, it is already penetrating the graft. From the second until the seventh day the purple becomes progressively mottled with lighter tones, and by the seventh day, it is diffusely pink. My observation clearly demonstrated that the grafts in which the thromboplastin fixation was used accomplished the first forty-eight hours of ordinary wound healing at the time of the operation. This forty-eight hour period is the first stage of the wound healing and virtually prevents the graft from having to go through that initial period of poor circulation following the operation, during which an appreciable number of grafts are lost from ischemia when the thromboplastin technique is not used.

SUMMARY OF CASES

In my series of cases, I have employed this procedure in 61 patients since May, 1944. Of these 61 cases, 33 were on granulating surfaces of one type or another and were on newly created wounds usually following the excision of a disabling cicatrix adjacent to a joint. Prior to using this method I had performed 17 skin grafts during the previous 23 months. Of this group, 5 were on newly formed wounds from the excision of cicatrices and 18 were on granulating wounds. The new wounds showed approximately 85 per cent viable skin graft and the granulating wounds showed approximately 50 per cent. A rather close observation of my cases prior to the advent of this new method was made because I was dissatisfied with the results, particularly on granulating surfaces. Since the employment of thromboplastin fixation technique beginning fifteen months ago, each graft has been studied carefully after two-week intervals following the operation to determine the surface area that has taken. In the following discussion the "take" is expressed in percentage. Of the 28 cicatrices that have been excised and grafts applied, which have been in the axilla, the anticubital fossa, the popliteal fossa about the heel, and around the other major joints, there was a 100 per cent take of the graft in every instance. Of the 32 grafts placed on granulating surfaces, the percentage of viable grafts has been 75, which seemed quite satisfactory

*Author's Note.—A large series of Kodachrome films are available to any surgeon wishing to see demonstrations of the more rapid attainment of blood supply by the grafts in which thromboplastin technique was employed. The films are an integral part of this work, but it was impractical to reproduce them in this publication.

because ordinarily takes are not nearly so high on a granulating recipient wound.

OTHER USES OF THROMBOPLASTIN FIXATION

It is not entirely new to reparative surgery that plasma can be used to advantage in the exterior treatment of wounds. The fact that plasma infusions add to the supply of fibrinogen and therefore of fibrin at the area of healing long ago suggested that it may promote healing if locally applied. There are reports of its use in sealing wounds of liver tissue in which suturing would lead only to further bleeding, and there are also reports of its employment in wounds of the spleen. Laceration of the face are the most suitable lesions for the employment of this method. Until the present time I have employed this technique in this type of lesion only 5 times, 3 wounds of the lip, 1 of the neck, and 1 of the cheek. In these cases, both plasma and cell extract were applied to the raw surface of each wound edge, and the edges were then carefully approximated with the fingers and held for two to three minutes. Unless there has been a substantial loss of tissue they will be adequately sealed. I have been gratified with the results in each instance. One case was a narrow avulsed pedicle of the face and it is felt that this technique was responsible for the survival of the skin flap, by virtue of the fact that both ischemia and foreign body reaction were eliminated by not using sutures.

CONCLUSIONS

In my work for the past fifteen months with this method, I have come to feel that there are some definite advantages and uses for thromboplastin fixation. In the first place it has the greatest number of takes and the highest percentage of living area in the individual graft.[1] It affords the optimum pressure of the graft against its bed and this pressure has not been attained by a mechanical bandage but by a physiological condition.[2] In addition, and of most importance, it affords a better and quicker nutrition to the graft itself by creating those conditions that Dr. Sano described as satisfactory in the test tube and the laboratory in tissue culture growth. In the second place a large bandage is eliminated. It requires much work and considerable time and skill in application, and even then bandages frequently loosen and slip. A third advantage is that no sutures are necessary. Frequently they will leave unsightly scars even when removed early, and they may also be the source of infection or additional bleeding. This is of particular value about the face. A fourth advantage is that the graft may be observed from day to day or from hour to hour if desired, which is of interest and of value in following the viability of the graft. Fifth, it is of distinct advantage in the operating room itself because it is a much quicker method. With the use of suture, plastic surgeons frequently require some two or more hours to apply a large free graft. Their meticulous technique and the use of an infinite number of interrupted or continuous sutures is very time consuming. The use of thromboplastin fixation eliminates these time consuming procedures. I feel that this simple combination of plasma and cell extract when properly used adds greatly to the armamentarium of the surgeon in this field of work.

SUMMARY

1. A relatively new method of skin graft fixation is described which employs plasma on the surface of the graft and white cells on the recipient area.

2. In the preparation of the material oxalate has been substituted for heparin since the former works quite as well, is less expensive, is easily obtained, and makes possible autoclaving the anticoagulant in a test tube before use.

3. The physiological considerations, opertive technique, and advantages of the method are described.

4. A series of skin graft cases using the method are reported with 100 per cent "take" in 28 cases of aseptic scar excision followed with skin grafting and 75 per cent "take" in 33 cases of grafts applied to granulating surfaces.

5. The method may also be used in fresh lacerations, especially of the face, to produce an immediate physiological healing by primary intention.

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SLEEPING PILL POISONING

Benzedrine, a drug used in the treatment of certain depressive conditions such as that produced by alcoholism, has been newly applied in the treatment of sleeping pill poisoning and proved to be highly successful, according to two doctors writing in the June 22 issue of *The Journal of the American Medical Association.*

The doctors—A. W. Freireich and J. W. Landsberg of Hempstead, N. Y.—treated 14 patients with poisoning from sleeping pills by giving them injections of benzedrine into the veins. Thirteen patients recovered completely except for a slight headache. The one patient who died had not received, in the authors' estimation, a sufficient quantity of the drug because it was not available.

OUTLOOK FOR INFANTS RECEIVING ANTI-Rh AGGLUTININS FROM ISOIMMUNIZATION OF MOTHERS

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The increased knowledge of hemolytic disease of the newborn (erythroblastosis fetalis) has provided the lay press with a fertile field for the implantation of this knowledge to the public. As a consequence more and more women are requesting that the Rh factor for themselves and their husbands be determined. Unfortunately today when that factor has been found to be Rh-negative in the female and Rh-positive in the male, those women fear multiple pregnancies and occasionally the first pregnancy. That this future might not be as dismal as previously thought is now beginning to appear. The data suggesting a brighter future in multiple pregnancies of the Rh-negative woman will be presented in this article.

It is known at the present time that there is a discrepancy between the incidence of marriages of Rh-negative women and Rh-positive men and frequency of hemolytic anemia of the newborn in pregnancies resulting from these marriages. Thirteen per cent of all matings involve an Rh-negative mother and Rh-positive father; but hemolytic anemia of the newborn (erythroblastosis fetalis) occurs only in 0.2 to 0.5 per cent of deliveries. The consideration of some of the variable factors in the pathogenesis of this disease helps to explain this variation.

1. The individual Rh factor may vary in its antigenic power. The Rh antigen as a rule is a weak antigen as compared to the agglutinogens A and B in man. This is reflected in the fact that usually several pregnancies are necessary to build up sufficient antibodies or rapid production of antibodies.

2. The ability of different persons to produce antibodies is known to vary considerably. This variation apparently is more marked in the production of antibodies for the Rh antigen.

3. The amount of Rh antigen that may enter the maternal circulation and amount of anti-Rh agglutinins that pass back to the fetus apparently varies a great deal in different mothers.

4. The amount of anti-Rh reaction factor that is found chiefly in Rh-negative blood serum may vary in different individuals and in different pregnancies. In a previous article[2] the difference in Rh-negative blood serum and Rh-positive blood serum in preventing Rh agglutination in vitro was demonstrated.

The values of several sera from Rh-negative donors' blood in preventing agglutination of Rh-positive cells with anti-Rh agglutinins are shown in table 1. For controls the sera of several Rh-positive donors were used.

TABLE 1.—*Effect of Incubation of Various Rh-Negative and Rh-Positive Blood Sera Upon Rh-Positive Cells Tested with Commercial Rh Testing Serum.*

Type of Test	Dilutions of Anti-Rh Testing Serum 1:5	1:10	1:15	1:20	1:30	1:40	1:60
Rh-Pos. (A) Red Blood Cells using Serum of Rh-Neg. (A) donors							
Mrs. P.	+	+—	+—	—	—	—	—
Mrs. C.	+—	+—	—	—	—	—	—
Mrs. B.	—	—	—	—	—	—	—
Rh-Pos. (O) Red Blood Cells Using Serum of Rh-Neg. (O) donors							
Mrs. H.	+—	+—	+—	+—	+—	+—	—
Mrs. McD.	—	—	—	—	—	—	—
Rh-Pos. (A) Red Blood Cells Using Serum of Rh-Pos. (A) donors							
X	+—	+—	+—	+—	+—	+—	+—
Y	+	+	+	+	+	+	+
Z	+	+	+	+	+	+	+—
Rh-Pos. (O) Red Blood Cells Using Serum of Rh-Pos. (O) donors							
A	+—	+—	+—	+—	—	—	—
B	+—	+—	+—	+—	+—	+—	+—

All dilutions were made with sera of Rh-negative and Rh-positive donors.

Data on the further observation of this protective factor and its variation is presented in table 2.

All mothers studied and reported in table 2 were Rh-negative, the infants Rh-positive, and the fathers Rh-positive. Infant A was the result of a first pregnancy and showed no anti-Rh agglutinins and only a small amount of anti-Rh reaction factor in his blood. His mother showed no anti-Rh agglutinins and a high amount of anti-Rh reaction factor.

The mother of infant B has two children living and well with a third infant dead of erythroblastosis fetalis eighteen months before delivery of infant B. Seven days before delivery this mother's blood showed anti-Rh agglutinins and twelve hours after delivery there were no demonstrable anti-Rh agglutinins present in her blood. Infant B showed weak anti-Rh agglutinins in his cord blood on delivery. The mother of infant B showed a titer of 1:32 of the anti-Rh reaction factor in her blood seven days before delivery and this increased fourfold on delivery. Infant B showed the same titer of anti-Rh reaction factor as his mother.

The mother of infant C has two children living and well. The third was delivered dead of erythroblastosis fetalis. This mother had an extremely high titer of anti-Rh agglutinins in her blood and no anti-Rh re-

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action factor. It was unfortunate that the blood of the infant delivered dead was not obtained for study.

The mother of infant D has three children living and well. In addition she has one child living who is a spastic and three infants dead, presumably of erythroblastosis fetalis. Her last infant, infant D, had erythroblastosis fetalis, associated with congenital bands obstructing the stomach and large intestine. Death occurred on the sixth day after delivery. The blood of the mother of infant D showed a weak titer of 1:12 of anti-Rh agglutinins and a very weak titer of 1:64 of the anti-Rh reaction factor. The infant showed a titer of 1:128 of anti-Rh agglutinins and a weak titer of 1:64 of the anti-Rh reaction factor. This infant died of intestinal obstruction associated with erythroblastosis fetalis on the sixth day of life.

In a previous report on the studies of the anti-Rh reaction factor, data were presented to show that the anti-Rh reaction factor in the serum of blood of an Rh-negative donor who was tested was effective in vitro in preventing agglutination by the anti-Rh agglutinins present in the blood of the mother giving birth to an erythroblastotic infant. The suggestion was made that regular infusions of such a serum to a mother during gestation of a possible erythroblastotic infant might be of value in salvaging her infant.

The question arises at this point as to whether or not the prevention of agglutination of Rh-positive cells in the presence of a potent anti-Rh agglutinin serum is the result of "blocking antibodies" in the serum of the Rh-negative donors tested. These "blocking antibodies" combine with their antigen but the reaction stops at this point in vitro and no agglutination or hemolysis occurs. The combination of these "blocking antibodies" with their antigen effectively prevents agglutination when potent anti-Rh agglutinins are added in vitro. Wiener[7] stated that on account of these "blocking antibodies" consisting of smaller molecules than agglutinins and therefore being able to traverse the placental barrier more readily into the fetal blood stream, the "blocking antibodies" are more important clinically than the agglutinins. The anti-Rh antigen-antibody reaction factor is different from the "blocking antibodies" because it occurs in serum of Rh-negative male donors who have received no blood transfusions and obviously could not be immunized by pregnancy. Second, "blocking antibodies" apparently have a priority to combine with their antigen over the anti-Rh agglutinin, whereas the anti-Rh antibody-antigen reaction factor is effective when its concentration is sufficient to protect the Rh antigen from combining with the anti-Rh agglutinin in vitro. Whether or not the anti-Rh antibody-antigen reaction factor is effective in preventing "blocking antibodies" from combining in vitro with their antigen I am not at this time prepared to state. Third, the "blocking antibody" once it combines with its antigen removes that antigen from the possibility of reacting with

TABLE 2.—*Titers of Agglutination of Anti-Rh Agglutinins and Anti-Rh Reaction Factors on Rh-Negative Mothers and Rh-Positive Infants.*

Dilutions	1:1	1:2	1:2	1:4	1:6	1:8	1:12	1:16	1:22	1:22	1:28	1:64	1:128	1:256
Anti-Rh agglut.														
A. Gravida 1	—	—	—	—	—	—	—	—	—	—	—			
Infant (Normal)	—	—	—	—	—	—	—	—	—	—	—			
B. Gravida 4	+		+	+—	—	—	—	—	—	—	—	(7 days before del.)		
(One infant dead, erythroblastosis)	—		—	—	—	—	—	—	—	—	—	(12 hr. after del.)		
Infant (Normal)	+—		+—	+—	+—	+—	+—	+—	+—	+—	—	—	—	
C. Gravida 3	+	+	+	+	+	+	+	+	+	+	—	—	—	
(Infant del. dead, erythroblastosis)														
D. Gravida 8	+—	+—	+—	+—	+—	+—	+—	—	—	—	—	—	—	—
(3 infants died, erythroblastosis. Last infant lived 4 days.)														
Infant 8	+	+	+	+—	+—	+—	+—	+—	+—	+—	+—	+—	+—	—
E. Gravida 6	+	+	+	+	+	+	+	+	+	+	+			
(3 infants died erythroblastosis. Last infant undel.)														
Anti-Rh Reaction Factor.														
A. Gravida 1	—	—	—	—	—	—	—	—	—	—	—	—	—	
Infant	+	+	+	+	+	+	+	+	+	+	+—	+—	—	
B. Gravida 4	+	+	+	+	+	+	+	+	+	+—	—	—	—	
(7 days before del.)														
Gravida 4	+	+	+	+	+	+	+—	+—	+—	+—	—	—	—	
(12 hrs. after del.)														
Infant Nor.	+	+	+	+	+	+	+—	+—	+—	+—	+—	+—	—	
C. Gravida 3	+	+	+	+	+	+	+	+	+	+	+—	+—	—	
D. Gravida 8	+	+	+	+	+	+	+	+	+	+	+—	+—	—	
Infant died fourth day	+	+	+	+	+	+	+	+	+	+	+	+	—	
E. Gravida 6	+	+	+	+	+	+	+	+	+	+	+	+	—	
Infant undel.														

All dilutions were made with serum of mothers or infants.

potent anti-Rh agglutinins so that those Rh-positive red blood cells act like Rh-negative red blood cells. The anti-Rh reaction factor may be removed from the Rh antigen so that that antigen will then react with the anti-Rh agglutinin.

Recent reports, in addition to the infant B reported in this study, have accumulated in the literature of newborn infants without symptoms of hemolytic anemia of the newborn being delivered of mothers with anti-Rh agglutinins in the maternal blood[4]. The role of the anti-Rh reaction factor has been suggested in one of the infants studied and it may have been the essential protective factor in others.

Mayes[6] has recently reported on the cord transfusions of infants born of Rh-negative mothers when those mothers have had a previous pregnancy. He stated that the use of the mother's blood rather than a donor's is contrary to the general rule, but so far in the main the mother's blood seems to agree with the babies. In view of the fact that those mothers may have a high degree of anti-Rh reaction factor in their blood, if their infant is undamaged by anti-Rh agglutinins or "blocking antibodies" up to the time of delivery, then such a procedure would not be contraindicated. An occasional mother, however, may have a small titer of the anti-Rh reaction factor and the use of her blood would not be indicated. However, the chances are that if she had such a weak titer of anti-Rh reaction factor, her infant would be born seriously damaged or dead.

The value of a single large transfusion in 1 case of erythroblastosis fetalis has been shown.[3] Bivings[1] also recently reported an infant with erythroblastosis fetalis given a single large transfusion of Rh-negative blood with complete recovery.

The routine determination of the Rh factor on all mothers before or at the beginning of pregnancy, the possible and hoped for protection with infusion during gestation of Rh-negative blood sera in Rh-negative mothers expecting Rh-positive infants, and the adequate cord transfusions of those infants at delivery may well change the outlook of hemolytic disease of the newborn.

For convenience and ease of treatment banks of Rh-negative blood and blood serum will be necessary. It may well be that commercial dried Rh-negative blood plasma in adequate future determined amounts will be available to the obstetrician together with adequately trained laboratory technicians to make determinations of titers of Rh agglutinins, Rh "blocking antibodies," and the anti-Rh reaction factor to guide the obstetrician in his treatment of Rh-negative mothers.

SUMMARY

1. A case study of an infant showing anti-Rh agglutinins in his blood as well as in his mother's blood and apparently protected by the anti-Rh reaction factor present in equal concentrations in his and his mother's blood is reported.

2. A brief review of some of the various factors operating in hemolytic disease of the newborn is presented. Evidence is reported which at the present time makes the outlook in hemolytic disease of the newborn not as dark as once believed.

3. The necessary therapeutic steps and means of taking those steps in hemolytic disease of the newborn are outlined.

4. Attention is called again to the fact that treatment of hemolytic disease of the newborn (erythroblastosis fetalis) is an obstetrical problem. It is hoped that the use of suitable Rh-negative blood and blood serum at regular intervals before delivery may result in the salvage of a large number of those infants.*

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ABSTRACT OF DISCUSSION

Dr. J. A. Nunn, San Antonio: I have enjoyed the splendid paper read by Dr. Bloxsom and am glad to hear about the anti-Rh reaction factor which is something new to me. I have not heard of it before nor have I seen anything about it in the voluminous literature on the Rh factors. The doctor has presented something new in the management of hemolytic disease of the newborn. Any method of treatment which promises a brighter future to the fetus or newborn who is exposed to the action of the anti-Rh agglutinins sounds encouraging to me. Heretofore efforts have been made to desensitize, with injections of packed Rh-positive red cells, the Rh-negative woman who has been sensitized by her Rh-positive fetus, but this treatment only further sensitizes the woman and makes bad matters worse for the fetus.

*Author's Note.—A final observation on infant E delivered to gravida 6 (see table 2) can be made at this time. The obstetrician was advised that since gravida 6 had very little anti-Rh reaction factor in her serum he should suggest that she be given an infusion of serum from an Rh-negative donor with a high titer of the anti-Rh reaction factor. This was done and gravida 6 refused. The infant at delivery seemed normal, and the obstetrician at my suggestion at once called the pediatrician who had taken care of the other children of this mother and informed him that the infant should receive some Rh-negative blood serum as its mother had very little protective factor in her blood. The pediatrician disagreed. Two days later this infant was dead of erythroblastosis fetalis. This infant had two opportunities for a possible survival. It was granted neither.

This naturally present anti-Rh reaction factor in the blood of Rh-negative persons evidently inhibits the Rh antigen-antibody reaction in Rh-negative mothers, who have been exposed to Rh-positive blood and thus prevents hemolytic disease in at least some of their fetuses. This probably explains the case, reported by Goldbloom and Lubinski, in which the mother had a high titer of anti-Rh agglutinins in her blood serum but her baby was not affected. I have read reports of a few infants with hemolytic disease who were given transfusions of their mother's blood instead of donors with apparent benefit and no reaction. The mothers of these infants must have had an abundance of the anti-Rh antigen-antibody reaction factor in their blood sera or these babies would have been made worse.

The infusion of sera from Rh negative males who have not been sensitized by transfusions to pregnant Rh-negative women who are expected to have erythroblastotie infants, especially if the titer of anti-Rh agglutinins rises, will probably prevent many neonatal deaths from hemolytic disease and greatly diminish the incidence of kernicterus in those who survive the acute disease.

THE USE OF FINE COTTON SUTURES IN EPISIOTOMY REPAIRS

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Occasionally, no matter how meticulous one is, he has difficulty with episiotomy repair. With the revival of early rising of the parturient woman,[1, 5] additional episiotomy complications have been encountered. I have therefore been alert to methods by which episiotomy repair technic could be improved. Many of the errors in technic and resultant faulty healing can be attributed to the type of suture material used, and this is particularly true of absorbable sutures.

When chromic catgut is used, there is a tendency to apply considerable force in approximating perineal muscle and fascia. This often produces a strangulation of tissue, followed by necrosis[3] with the establishment of an area of lowered tissue resistance. Furthermore, the tensile strength of catgut is not constant. The tensile strength of chromic catgut decreases rapidly in tissues.[2]

During the past few years there has been a trend toward the use of nonabsorbable suture materials. Recently, spool cotton has acquired prominence in surgical practice.[4] The advantages of cotton sutures rest largely upon the fact that the material maintains satisfactory tensile strength in tissues; excites very little, if any, fibroblastic proliferation; and the fact that the healing process is "dry" rather than moist as it often is in the case of chromic catgut sutures.

Paradoxically, the disadvantages of cotton sutures are predominantly advantages. Fine, interrupted cotton sutures must be used; consequently, the sutures break easily, thus influencing the operator to handle tissues more carefully. In changing from catgut to cotton sutures, the episiotomy repair technic is altered considerably, that is, considerably improved. Cotton, like all nonabsorbable sutures, requires exactness of technic with small bites of tissue included in each suture. Furthermore, another advantage is that spool cotton is easily sterilized without reduction in its tensile strength.

Preparation of the suture material is as follows: No. 80 white spool cotton is cut into approximately 9 inch lengths coiled, and placed in a 10 cc. test tube. Enough suture material is prepared for one episiotomy repair. The mouth of the tube is closed with a cotton ball, and the tube and its contents are sterilized in a steam-pressure autoclave for twenty minutes.

In this report the episiotomy repair technic is briefly as follows: The vaginal mucosa to the hymeneal ring is approximated with interrupted, absorbable, triple O chromic catgut sutures. This usually requires four or five sutures placed about 1.5 cm. apart. One or two interrupted sutures are placed distal to the hymeneal ring. Then the severed muscles and fascia are brought together from within outward by two or three rows (depending upon the depth of the incision) of interrupted No. 80 cotton sutures. The surgical knots must be tied accurately—preferably with three knots. The suture is cut on the third knot, thus leaving no free ends in the approximated tissues. The perineal body is built up in anatomic layers under the vaginal mucosa outward to the perineal skin. Skin closure may be either by interrupted triple O chromic catgut sutures, or by the subcuticular stitch method.

In 82 episiotomy repairs by this technic, the results were gratifying. There were no wound complications in any of the repairs. There was noticeable absence of incisional discomfort in all cases, in spite of the practice of early ambulation. At the sixth week postpartum examination, induration and the thickness of the scar were minimal. In fact, it was difficult to visualize or palpate the repair area.

Changing to fine cotton sutures was, at first, difficult. The fine, very flexible material seemed almost impossible to use. However, with increased use it was found easier to handle small bites of tissue. Rapid manipulation of the suture is enhanced by cutting the material into appropriate lengths prior to its use. The actual time consumed in this type of repair is increased from two to five minutes over the absorbable suture method.

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It is felt that the additional time consumed is more than repaid for by the absence of wound complications, the marked decrease in immediate and remote perineal discomfort, the reduction in size and increased pliability of the healed episiotomy incision, and the cosmetic results.

CONCLUSIONS

1. The advantages of fine cotton over absorbable materials have been discussed.

2. The method of episiotomy repair used in 82 cases has been briefly presented.

3. Immediate and remote results obtained justify the use of fine spool cotton sutures, as evidenced by a reduction in postpartum perineal discomfort and absence of wound complications and wound infection.

4. The gratifying results in this method of repair may be attributed largely to the lack of tissue reaction produced by fine cotton.

5. The technical difficulties encountered in the cotton suture method tend to improve the repair technic.

6. The suture material will withstand the stress and strain of early ambulation with less discomfort and fewer complications than will absorbable sutures.

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1402 Medical Arts Bldg.

ABSTRACT OF DISCUSSION

Dr. Herman L. Gardner, Houston: Dr. Morse has presented what is no doubt an improvement over the old method of chrome sutures. It is admitted that chrome is very painful to most patients, sometimes even to the extent of patients dreading having another baby. Using a subcuticular instead of an interrupted stitch in the skin relieves the pain somewhat but is not the answer. There is always some amount of pain. I have never seen cotton used in the perineum. I would like to ask Dr. Morse what happens to the pieces of cotton, especially at the time of the next episiotomy?

Dr. Nicholson J. Eastman, Baltimore: This is undoubtedly a very practical paper and I would like to congratulate the author. I have been trying one thing and another over a period of years in the technic of episiotomy. I have had no experience with cotton in the repair of the perineum as the Easterners have used it. It has been mentioned once or twice by patients with episiotomy that they have a good deal of pain—this pain can be minimized by the type of suture material. My impression is that in the average obstetrician's hands, instances of discomfort, faulty healing, breakdown of the wound, and so forth depend more on the type of episiotomy than on the suture. From the viewpoint of comfort after delivery, good anatomical results, and good healing, the median episiotomy is preferable to the median-lateral. Most obstetricians are afraid of the median episiotomy because of the possibility of third degree lacerations, which they feel they overcome with a median-lateral episiotomy. I had occasion to review recently some 40 to 50 third degree lacerations that were repaired and found only one-fourth with the rectum involved. These patients did beautifully; no discomfort, no trouble with bowel movements, good sphincter control, and no fistulae. Some patients with median episiotomy never knew they had an episiotomy, which is not true of the median-lateral.

The reason for fear of the third degree laceration is probably a hangover of the days when the majority of women were delivered at home without assistance. Anesthetists were lacking and the operator was quite aware of this during his repair of third degree lacerations. It is quite understandable that his repair was faulty and led to fistulae, lack of control, and other unsatisfactory results. Lighting was bad; it was easy to miss some of the places needing repair, and difficult to do the repair. The long considered stigma of lacerations is minimized with the median episiotomy.

Dr. Robert A. Johnston, Houston: I agree with Dr. Eastman about the median episiotomy. It is much more pleasant for the patient than the median-lateral type. One thing in regard to the use of interrupted sutures: I formerly used a continuous suture which works very well, but at times the patients seemed to suffer and I was called out on occasion to give a hypodermic for relief. Interrupted sutures will allow a great deal more relief. The explanation is very apparent: swelling and edema cause pain; interrupted sutures allow the serum to escape more easily than when the suture is closed too tight as in the continuous method.

Dr. Morse, closing: I think the direction of the incision makes a great difference in healing. The nearer the incision approaches the midline, the easier and more anatomical the repair. Many of the episiotomies in this report were of the median type.

The type of suture material plays an important role in the character of the healing. The finer suture materials are preferable.

In answer to Dr. Gardner's question: I have intentionally looked for the pieces of cotton in repeat episiotomies and have found that the cotton sutures remain in the tissue very little altered with no apparent tissue reaction about them.

SCHERING AWARD FOR MEDICAL STUDENTS

The Schering Award for 1946, a $1,000 essay competition open to undergraduate medical students and designed to encourage studies in endocrinology, will be awarded for essays on "The Role of Hormones in Sterility." Three judges prominent in endocrinology will choose three essays to receive awards given by the Schering Corporation of Bloomfield, N. J. For the best thesis submitted, an award of $500 will be given; for the second and third best papers, $300 and $200, respectively.

Twenty years ago, the idea of going directly to the people and searching for tuberculosis by means of the x-ray, among large groups of apparently healthy individuals, would have sounded like trying to move the mountain to Mohammed—a supposedly impossible task. Today, we are virtually doing that very thing. Modern science and ingenuity have given us the means by which we are able to find the early case of pulmonary tuberculosis. Education of the people has made them see the wisdom of the early diagnosis.—Ann. Rept., Wisconsin Anti-TB Assn., 1944-45.

A SIMPLE TECHNIC FOR THE CLOSURE OF THE CATARACT INCISION

RAY K. DAILY, M. D., F. A. C. S.
and
LOUIS DAILY, JR., M. D.
HOUSTON, TEXAS

The progress made in cataract surgery within the last two decades has completely changed our technic and revolutionized our attitude in the management of cataract cases. For example, the factor of maturity of cataract has practically lost its significance. It is not necessary to prepare the patient for a period of blindness. In the development of the technic, akinesis, retrobulbar injection, and superior rectus suture have become standardized procedures. Now and then one still encounters in the literature a voice depreciating these procedures; we react to it with patience, but do not take it seriously. During this period the extracapsular extraction has gradually given way to the intracapsular. Most of the extracapsular extractions today happen because attempted intracapsulars fail. The analysis of a large amount of material from large clinics has definitely demonstrated that the best way to avoid postoperative iridocyclitis and glaucoma is to remove the lens in the capsule. The literature of the last decade shows a growing tendency to replace the Graefe knife with the keratome in making the corneal incision. This change may be classed with the safe-guarding procedures; a well carried out corneal section requires experience and dexterity, which means that a number of eyes are sacrificed in the process of acquiring experience. If the knife is tilted forwards the section is at least partially corneal with slow delayed healing in that part of the wound. If the knife is tilted backwards it cuts too far in the sclera with injury to the ciliary body and postoperative cyclitis. Unintentional opening of the lens capsule and the iris falling over the knife are less important complications. The keratome incision, enlarged with scissors, permits even the beginning surgeon to place the incision accurately in the limbus; there is no bevelling and the size of the incision is practically the same at the outer and at the inner edges of the wound. It promotes rapid coaptation of the wound, and produces a regular cicatrix which results in a minimum of postoperative astigmatism.

There is much in the literature of the last ten years on methods of closing the wound. The desirability of a sutured wound has been established. Those of us who operated with no sutures at all know that in a large number of cases we got good results without sutures. Without a doubt, however, suturing the wound has raised the percentage of successful extractions. The conjunctival suture advocated in the late thirties is gradually being replaced by some form of corneoscleral suture, and the literature of the last decade is full of new sutures. The reason for the number and variety of the advocated sutures is the fact that the ideal suture has not as yet been found. Conjunctival sutures which are easy to introduce, before or after the delivery of the lens, are not adequate to close the wound firmly in cases complicated by vitreous loss. Some sutures are not secure enough to produce good coaptation and rapid closure of the wound in its entire extent, and others, while effective, are so complicated and cumbersome that with them in place it requires considerable surgical experience and dexterity to complete the operation, which makes them unsuitable for the occasional operator or the young surgeon.

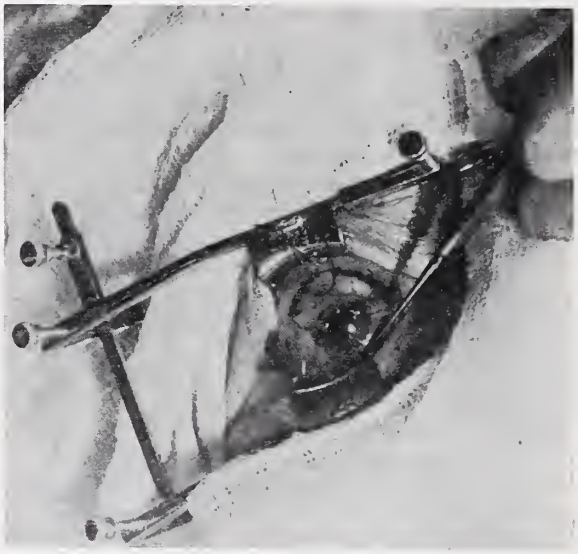

FIG. 1. Eyeball immobilized. Conjunctival flap made and reflected over the cornea. Scleroconjunctival suture introduced into the episclera just above the limbus.

In our opinion the criterion for the evaluation of any surgical procedure should be its effectiveness in the hands of the average operator. Corneal sutures are not without objection, since they open a channel for infection in a tissue of low resistance. Besides it is generally agreed that they should be introduced before the section is made; the making of a section between the loops of a suture is often a complicated and difficult

Prepared for the Section on Eye, Ear, Nose, and Throat, State Medical Association of Texas Annual Session, Galveston, May 8-10, 1945, cancelled because of war conditions.

task. Most of the corneoscleral sutures are introduced over the wound and not actually through it; such sutures tend to invert the conjunctiva and predispose to the ingrowth of epithelium into the anterior chamber. The function of a suture should be to provide firm closure of the wound even in case of vitreous loss, to prevent vitreous and iris prolapse, and to shut off the anterior chamber from the conjunctival sac. Elschnig claimed that any suture diminishes the tendency to postoperative hyphemia. If it promotes perfect wound coaptation, it should produce a minimum of postoperative astigmatism.

Having tried practically all sutures described in the literature, we have finally developed a technic which we find to fulfill

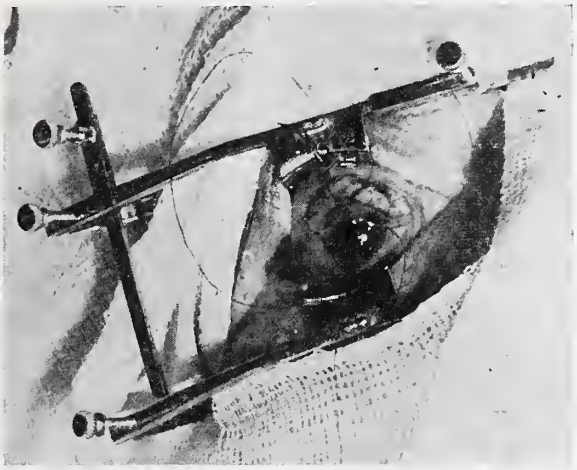

Fig. 2. Anterior chamber opened, and scleroconjunctival suture introduced through the base of the conjunctival flap.

the above mentioned requirements and which is simple enough to be successful in the hands of the young and average operator. The steps of the operation are carried out as follows: akinesis, retrobulbar injection; injection of superior rectus, and injection of conjunctiva around the limbus; superior rectus suture tied to Guist speculum, sharp right-angled hook introduced into the episclera at the limbus at the lower end of the vertical corneal meridian, providing perfect fixation of the eyeball.

With sharp-pointed scissors a conjunctival incision is made 5 mm. from the cornea around the upper third of the limbus. Below each side of the incision the conjunctiva is undermined to half of the corneal circumference; this makes the subsequent corneal incision partially subconjunctival; the conjunctival flap thus outlined is separated from the sclera and reflected over the cornea exposing the limbus. A double armed atraumatic 6-0 silk suture is now introduced into the episclera at the limbus and parallel to it, at the upper end of the vertical meridian, taking a 3 mm. bite. The two ends of the suture are laid over the region of the eyebrow and out of the way (Fig. 1).

The corneal section is now made at the limbus with a Graefe knife or keratome. If made with the knife the conjunctival flap has to be brushed back into place. If made with the keratome it is merely held up with forceps by an assistant, as in making a keratome incision for an iridectomy or iridencleisis. The keratome incision is the easier of the two. As soon as the anterior chamber is opened the hook is removed; the two ends of the suture are now passed through the base of the conjunctival flap as close to the corneal tissue as possible. The conjunctiva in this area is firmly attached and does not give or stretch, so that when the suture is tied the wound is closed firmly. Then the loops of the suture are so arranged that their lower ends may be used as a traction suture on the cornea, pulling it downward (Fig. 2).

The limbal incision is enlarged on each side with curved blunt-pointed scissors to one-half of the corneal circumference; part of the limbal incision is subconjunctival. Iridectomy, total or peripheral, or iridotomy

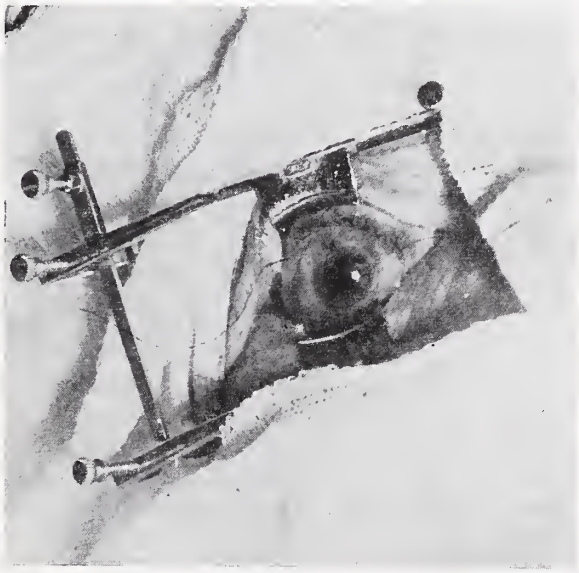

Fig. 3. Operation completed. Scleroconjunctival suture tied, and running conjunctival suture closes conjunctival incision.

is made according to the indications of each individual case, or to the surgeon's preference. The lens is extracted in the capsule or after a capsulotomy. The iris pillars are stroked into place. The suture is pulled until the wound edges are in good coaptation and tied over the conjunctiva. At this point the coaptation of the entire wound can be inspected. The conjunctival flap is smoothed

over the sclera and a running suture closes the entire conjunctival wound (Fig. 3).

This is a water-tight suture, and frequently before it is completed one can see the anterior chamber restored. If it is not restored we introduce a bubble of sterile air into the anterior chamber. At first the conjunctival flap may appear to clutter the operative field, but since it is freely movable it really interferes but little and its advantages far outweigh this objection. It should not be handled unnecessarily with fixation forceps.

The separation of the conjunctiva at the limbus is per se conducive to better coaptation of the wound edges. After the conjunctival flap is replaced the anterior chamber is completely isolated from the conjunctival sac. Epithelization of the anterior chamber, which is not a very rare and is a very grave postoperative complication, is definitely eliminated. The entire limbal incision is covered with conjunctiva. There is no deformation of the cornea, and the postoperative astigmatism is reduced to a minimum. Another advantage of a wide conjunctival flap is the rapid restoration of the vascular and nerve network at the limbus. After ten days the circulation at the limbus appears uniform.

Postoperatively the large conjunctival flap appears more edematous than in cases with a small flap, because a vascular tissue reacts more vigorously than an avascular flap. After three to four weeks the limbus incision is practically invisible and the conjunctival scar is inconspicuous.

The sutures are removed on the eighth day: The central suture is cut with scissors and then withdrawn with a forceps. The running suture grasped at one end slips out easily. Having used this technic in 100 cases, we believe that it affords the best postoperative course, and a minimum of postoperative complications.

SUMMARY

A new method of closing the cataract incision is reported. The merits claimed for it are:

1. The ability to make an accurate limbus incision.
2. Accurate coaptation of the wound.
3. Immediate postoperative isolation of the anterior chamber from the conjunctival sac.
4. Rapid restoration of the anterior chamber.
5. Firm and rapid cicatrization.
6. A minimum of postoperative astigmatism.

1117-19 Medical Arts Building.

ULCERATIVE COLITIS WITH PERFORATION IN A NEWBORN

REPORT OF A CASE

JOHN A. HART, M. D., F. A. C. S.
BEAUMONT, TEXAS

Acute surgical emergencies in the newborn are commonly due to congenital malformations such as atresia at the anorectal junction, duodenum, and other sites of embryologic events. No child is too young to have peritonitis. It has been reported in the fetus from poisons circulating through the mother's blood in septic cases. Septic peritonitis in the newborn most commonly originates in an omphalitis; however, it may result from trauma, malformation, intussusception, strangulation of the intestines, or from diseases arising in the gastro-intestinal tract or its appendages. The case herein reported is of interest because of its rarity, its early onset, and its fulminating course.

CASE REPORT

A girl was delivered at home from a healthy mother at 3:00 a. m., March 20, 1942. At 1:00 p. m. the same day, the baby began vomiting and passing frequent bloody stools. The abdomen became markedly distended and the temperature rose to 101 F. A pediatrician sent the baby to the hospital.

Physical examination revealed a well developed and nourished girl weighing about 7 pounds. The temperature was 101 F., pulse 140, and respiration 40. No lymphatic glands were palpable. Ear, eyes, nose, and throat appeared normal. There was no nuclear rigidity. The lungs were clear. The umbilicus presented no discharge. The abdomen was greatly distended. No masses were palpable rectally. There was a hemorrhagic mucus discharge from the anus. The extremities were normal.

The clinical laboratory report was as follows: red cells 7,500,000; white cells 34,400; hemoglobin 150 per cent; polymorphonuclear leukocytes 90 per cent; large lymphocytes 5 per cent; small lymphocytes 5 per cent; coagulation time 8 minutes, 15 seconds; bleeding time 4 minutes. Three cultures were made from the mucus discharge from the rectum. The smears made from the cultures revealed growth of many gram-negative and gram-positive bacilli. Smears from the discharge from the rectum revealed few gram-negative and gram-positive bacilli. Smears from the discharge from the rectum revealed no ameba, many red blood cells and epithelial cells. Roentgen examination revealed free gas in the abdomen, indicating either a ruptured abdominal viscus or ruptured diaphragm. The latter being rare, the condition was believed to be ruptured abdominal viscus. There were no signs of obstruction.

The preoperative diagnosis was perforation of the hollow viscus and generalized peritonitis.

Preoperative care included administration of vitamin K and sodium luminal gr. 1/8. A duodenal tube was inserted and a large amount of bile colored drainage was recovered. A rectal tube was inserted and a large amount of flatus was expelled. Hartmann's solution (50 cc.) was given subcutaneously. The anesthetic used was ether—open drip.

The operation began at 12:05 a. m., March 21. A midline abdominal incision was made. The

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transverse colon was found to be adhered to the liver by thin grayish adhesions. On separating these, a thin yellow fluid exuded from the peritoneal cavity. The serosa of the exposed viscera was covered with a thin fibrinous exudate. Two ragged, necrotic grayish perforations about 1 cm. in diameter were found on the anterior surface of the transverse colon, about 6 cm. apart. The ragged edges were trimmed and perforations closed with triple O interrupted and a second row of triple O continuous sutures. One Gm. of sulfanilamide was placed about the perforation. The peritoneum was closed with continuous OO sutures, the fascia with a continuous O suture, and the skin with interrupted silkworm gut, with retention sutures. A catheter had been left in the peritoneal cavity and after closure 50 cc. of normal saline was injected through this catheter into the peritoneal cavity and the catheter removed.

Pathological Observations.—Microsection of the specimen (two pieces of tissue from the edge of the ulcer) revealed almost complete destruction of the mucosal epithelium, the mucosa being represented by an acute purulent exudate. The inflammatory change extended through the wall. There was involvement of the serosa with a purulent exudate infiltrating the pericolic fatty tissue.

The baby was placed in an incubator and a duodenal tube was inserted. Fifty cc. Hartmann's solution was given subcutaneously every four hours. The temperature rose to 101.6 F. Oxygen was given through a nasal catheter. The baby continued to have frequent bloody stools. The child voided involuntarily at 11:30 a. m. The temperature rose to 104 F. and respiration to 60. The baby was cyanotic. Coramine 2 mg. was given every three hours. The baby was crying and was very restless. Returns from the duodenal tube were dark. The abdomen was soft. Respiration became very rapid and labored. About six hours later, the abdomen became distended again. The patient became more cyanotic, the pulse imperceptible, and the baby died at 10:00 a. m. March 23, 1942.

Autospy Study (Dr. Ellen Furey, Beaumont).—"This is the body (unembalmed) of a female newborn. There is a generalized yellowish-green discoloration of the skin. There is a midline abdominal incision. The incision is pulled apart readily and it appears to be healing, a plastic exudate being present over the cut edges and no pus or pus pockets noted. However, when the peritoneum is reached a generalized peritonitis is noted. The intestinal coils, especially of the upper abdomen, are covered with fibrino-purulent exudate and about a half pint of sero-sanguinous fluid is present in the abdominal cavity.

"There are two sutured areas (sites of perforated ulcers) located in the transverse colon. These sutured areas are competent and show no leakage on pressure. The wall of the transverse colon is exceedingly inflamed and thickened. There is a patchy ulceration of the mucosa of the ascending and transverse colon, and the patches of pseudomembrane are present. In the descending colon there is evidence of inflammatory change and the mucosa is thick and injected, but no definite ulcers can be made out. The inflammatory change is seen to extend to 4 cm. from the anus. The lower rectum appears free of inflammation, only excess mucus clinging to its mucosa. The cecum and small intestines appear normal. The appendix lies free over the pelvic brim. Its serosa is injected especially at the tip but mucosa and submucosa appear uninvolved.

"The esophagus and stomach are essentially normal.

"The pancreas lies in normal position but as one approaches the head of the pancreas it is found to be closely adhered to the posterior abdominal wall against the right side of the vertebral column. The pancreatic head penetrates the duodenal wall at the site of the ampulla of Vater. Thus pancreatic tissue lies between duodenal mucosa and the two outer coats of the duodenum. Apparently there is no obstruction to the ampulla. This pancreatic mass measures 2 by 1 by 0.5 cm. The duodenal lumen above the mass is moderately dilated, then somewhat constricted at the mass, and then becomes of normal width just distal to the mass.

"The above comprise the significant observations. The jaundice appears to be due to a toxic change in liver parenchyma, that is, the liver is slightly enlarged, edges rounded, and the parenchyma is jaundiced. The liver capsule has fibrinopurulent exudate on it. There is no obstruction to the bile ducts. The gallbladder appears normal. The thymus, heart, lungs, kidneys, and spleen appear essentially normal. Petechiae are present in visceral pleurae and pericardium. Adrenals are congested and the left adrenal contains a cortical adenoma 4 cm. in diameter. The uterus appears normal except for hypertrophy and elongation of the posterior cervical lip. The fallopian tubes and ovaries appear normal. The urinary bladder appears normal. The brain is not examined.

"The pathological diagnosis is acute ulceration of the transverse colon with perforation; acute ulcerative and pseudomembranous colitis; generalized peritonitis; petechiae in visceral pericardium and pleurae; ectopic pancreatic tissue in the wall of the duodenum; cortical adenoma of the left adrenal; and jaundice (toxic)."

SUMMARY

A moderate review of the literature has been made for similar cases without success. The rapid spread of this infection with necrosis and perforation of the colon with generalized peritonitis indicated a very virulent disease in a patient of very lowered resistance. The demonstration of free air in the peritoneal cavity by flat roentgen films emphasizes the importance of this procedure in obscure acute abdominal emergencies.

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MISCELLANEOUS

COMING MEETINGS AND CLINICS

State Medical Association of Texas, Dallas, May 5-8, 1947. Dr. C. C. Cody, Jr., Houston, President; Dr. Holman Taylor, 1404 W. El Paso St., Fort Worth 3, Secretary.

American Medical Association, House of Delegates, Chicago, December, 1946; Regular General Session, Atlantic City, N. J., June 9-13, 1947. Dr. Harrison H. Shoulders, Nashville, Tenn., President; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secretary.

Southern Medical Association, Miami, Fla., November 4-7, 1946. Dr. M. Y. Dabney, Birmingham, Ala., President; C. P. Loranz, Empire Building, Birmingham, Ala., Secretary-Manager.

Southwest Allergy Forum, Shreveport, La., April, 1947. Dr. W. H. Browning, Shreveport, La., President; Dr. Sim Hulsey, Medical Arts Bldg., Fort Worth, Secretary.

Texas Association of Medical Anesthetists, Dallas, May, 1947. Dr. Claudia Potter, Temple, President; Dr. Russell Bonham, Box 6237, Houston, Secretary.

Texas Association of Obstetricians and Gynecologists, Galveston, November 2, 1946. Dr. Allen McMurrey, Houston, President; Dr. Julius McIver, 714 Medical Arts Building, Dallas, Secretary.

Texas Chapter, American College of Chest Physicians. Dr. R. G. McCorkle, San Antonio, President; Dr. Elliott Mendenhall, 1217 Medical Arts Bldg., Dallas, Secretary.

Texas Club of Internists. Dr. Robert M. Barton, Dallas, President; Dr. Julian C. Barton, 414 Navarro St., San Antonio, Secretary.

Texas Hospital Association, Houston, March 27-29, 1947. Tol Terrell, Harris Memorial Methodist Hospital, Fort Worth, President; Mrs. Ruth Barnhart, 720 College Ave., Dallas, Secretary.

Texas Neuropsychiatric Association, Dallas, May, 1947. Dr. Fred T. Rogers, Dallas, President; Dr. David Wade, 604 Capital National Bank Bldg., Austin, Secretary.

Texas Ophthalmological and Otolaryngological Society, Dallas, December, 1946. Dr. C. B. Williams, Mineral Wells, President; Dr. E. D. Dumas, 425 Medical Arts Bldg., San Antonio, Secretary.

Texas Orthopedic Society. Dr. E. A. Cayo, San Antonio, President; Dr. Edward Smith, 1215 Walker Ave., Houston, Secretary.

Texas Pediatric Society, Fort Worth, October 4-5, 1946. Dr. Max Woodward, Sherman, President; Dr. John E. Ashby, 3610 Fairmount, Dallas, Secretary.

Texas Public Health Association, Dallas. Dr. L. P. Walter, Austin, President; Mr. Earle W. Sudderth, Dallas County Health Department, Court House, Dallas, Secretary.

Texas Radiological Society, January, 1947. Dr. Herman Klapproth, Sherman, President; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secretary.

Texas Railway and Traumatic Surgical Association. Dr. F. L. Snyder, Fort Worth, President; Dr. Ross Trigg, First National Bank Bldg., Fort Worth, Secretary.

Texas Society for Mental Hygiene. Dr. Jack R. Ewalt, University of Texas Medical Branch, Galveston, President; Mrs. Elizabeth F. Gardner, 1617 Watchhill Road, Austin 21, Executive Secretary.

Texas Society of Gastro-Enterologists and Proctologists, Dallas, May, 1947. Dr. Tom E. Smith, Dallas, President; Dr. D. L. Curb, 704 Dallas Ave., Houston, Secretary.

Texas Society of Pathologists, Houston, January, 1947. Dr. May Owen, Fort Worth, President; Dr. C. T. Ashworth, Southwestern Medical College, Dallas, Secretary.

Texas State Heart Association, Dallas, May, 1947. Dr. Robert M. Barton, Dallas, President; Dr. M. B. Whitten, Medical Arts Bldg., Dallas, Secretary.

Texas Surgical Society, Houston, October 7-8, 1946. Dr. G. V. Brindley, Temple, President; Dr. Walter Stuck, 1426 Nix Professional Building, San Antonio, Secretary.

Texas Tuberculosis Association, Houston, September 16-17, 1946. Dr. J. B. White, Amarillo, President; Miss Pansy Nichols, 700 Brazos, Austin, Executive Secretary.

Third Panhandle, District Medical Society, Lubbock, October 8-9, 1946. Dr. W. A. Carroll, Claude, President; Dr. George Powers, Fisk Bldg., Amarillo, Secretary.

Fourth District Medical Society, Brady, November, 1946. Dr. H. L. Locker, Brownwood, President; Dr. Glenn H. Ricks, Brady, Secretary.

Seventh, Austin, District Society, Austin, July, 1946. Dr. Robert B. Morrison, Austin, President; Dr. M. I. Brown, Capital National Bank Bldg., Austin, Secretary.

Eighth, Ninth and Tenth Districts Medical Society, Orange, April, 1947. Dr. Walter F. Hasskarl, Brenham, President; Dr. George W. Waldron, Medical Arts Bldg., Houston, Secretary.

Eleventh District Society, Palestine, October, 1946. Dr. L. L. Travis, Jacksonville, President; Dr. C. B. Young, 929 S. Confederate, Tyler, Secretary.

Twelfth, Central Texas District Society, Corsicana, July 9, 1946. Dr. Thomas G. Glass, Marlin, President; Dr. H. F. Connally, Jr., Amicable Bldg., Waco, Secretary.

Thirteenth, Northwest District Society. Dr. A. L. Roberts, Fort Worth President; Dr. Joe R. Wise, 1212 W. Lancaster, Fort Worth, Secretary.

Fourteenth District Society, Dallas, December 10, 1946. Dr. C. B. Thayer, Gainesville, President; Dr. V. L. Tuck, Sherman, Secretary.

Fifteenth, Northeast Texas, District Society, October 8, 1946. Dr. Frank Littlejohn, Marshall, President; Dr. Henry H. Neihuss, Greggton, Secretary.

CLINICS

Dallas Southern Clinical Conference, Dallas, March 17-20, 1947. Miss Thelma J. Webb, 1133 Medical Arts Bldg., Dallas 1, Executive Secretary.

Post Graduate Medical Assembly of South Texas, Houston, December 3-5, 1946. Secretary, 229 Medical Arts Building, Houston.

BIOLOGICAL PHOTOGRAPHIC ASSOCIATION

The Biological Photographic Association will meet at Hotel Bismarck, Chicago, September 6-8. The planning and production of teaching motion picture films will be discussed by experts. New equipment for both still and motion picture photography will be demonstrated. Discussions will be held on the preparation of scientific exhibits; the classifications, indexing, and filing of medical illustrative material, and the Veterans Administration's program for obtaining medical illustration material will be described.

The Biological Photographic Association, a nonprofit organization, was formed in 1931 to raise the standards in photography for teaching and research, and to act as a clearing-house for information on photographic methods. Further information may be obtained from the Secretary, Biological Photographic Association. University Office, Magee Hospital, Pittsburgh 13, Pa.

TEXAS TUBERCULOSIS ASSOCIATION

Texas Tuberculosis Association officers are planning simultaneous programs for medical workers and for nonmedical and lay workers at the annual meeting September 16-17 at the Rice Hotel, Houston, the first such meeting held in several years. In addition to the scientific and educational programs, business meetings of the association and of its board of directors and of the Texas Chapter, American Trudeau Society and the Texas Conference of Tuberculosis Secretaries will be held.

Dr. Julius Lane Wilson, associate professor of medicine, Tulane University, New Orleans, and past-president of the American Trudeau Society, will deliver the principal address at a dinner-business meeting of the Texas Tuberculosis Association the evening of September 16. The Trudeau Society and the Tuberculosis Secretaries will have luncheon meetings the same day, while the following day one luncheon will be held for the board of directors of the Tuberculosis Association and another for nonmembers of the board, at which Dr. F. A. Musacchio, director of the Webb County Health Unit, will speak.

The public health program, for nonmedical workers in tuberculosis associations and health departments and lay members of boards of directors, is being arranged by Miss Emmeline Renis, Houston; Mrs. Agnes George, Beaumont; and Mrs. Virginia Kiker, Tyler. Program planning in health education and for tuberculosis nurses, rehabilitation of the tuberculous, development of social services for tuberculosis patients, personnel and administrative problems of local tuberculosis associations, and education programs among special racial groups will be considered. Dr. R. Alec Brown, Houston, will speak on x-ray in mass case finding programs. Dr. Howard E. Smith, Austin, will discuss the paper.

The medical section program is being prepared by a committee from the Texas Chapter of the American Trudeau Society, composed of Dr. J. Edward Johnson, Austin, chairman; Dr. Edwin G. Faber, Tyler; Dr. Robert J. Hanks, Waco; Dr. Howard E. Smith, Austin; and Dr. James E. Dailey. Houston. The tentative scientific program arranged by this committee follows:

MEDICAL SECTION PROGRAM

A Rare Tumor of the Bronchus with Successful Pneumonectomy: Case Report—Dr. J. R. Phillips, Houston, and Dr. George R. Hodell, Houston.

Some New Procedures in Tuberculosis Surgery—Dr. Donald Paulson, Dallas.
Discussion—Dr. J. W. Nixon, San Antonio.

Legislative Implications of Adequate Tuberculosis Control—Dr. J. W. Laws.

Tuberculosis and Cancer of the Lung: Errors in Diagnosis—Dr. H. T. Barkley, Houston.

Pulmonary Resection for Lung Suppuration—Dr. James E. Dailey, Houston.

The Problem of Tuberculosis in Industry—Dr. Carl U. Dernehl, Galveston.

Mediastinal Emphysema and Pneumothorax in Newborn Infants —Dr. George W. Salmon, Houston.
Discussion—Dr. Sim Hulsey, Fort Worth.

Physical Examination of the Chest in Pulmonary Disease—Dr. James A. Greene, Houston.
Discussion—Dr. David McCullough, Kerrville.

Bronchoscopy in Pulmonary Disease—Dr. Robert G. Shaw, Dallas.
Discussion—Dr. John Chapman, Dallas.

Certain Cardiovascular Diseases Commonly Confused with Pulmonary Disease—Dr. Don W. Chapman, Houston.
Discussion—Dr. Tinsley Harrison, Dallas.

Fungus Diseases of the Lungs—Dr. David Smith, Durham, N. C.

X-Ray Conference—Dr. Russell H. Morgan, Chicago, Ill.

MEDICAL OFFICERS RETURNING TO TEXAS*

(Corrections: G. F. Mood, formerly of Houston, has returned to Greenville, Miss.; Roger Stevenson, formerly of San Antonio, to Kerrville.)

NAME	Serv.†	Location	Release Date
Anderson-Houston-Leon Counties			
5. Carrington, Dewitte C.	A	Marquez	
6. Pickett, William H.	A	Palestine	
Angelina County			
4. Clement, Jennings C.	A	Lufkin	
Bexar County			
109. Borsheim, Raymond S.	A	San Antonio	
110. Gossett, Robert F.	A	San Antonio	
111. Hudson, Granville W.	A	San Antonio	
112. Kellam, Seth W.	A	San Antonio[1]	
113. Loehr, William M.	A	San Antonio	
114. Moore, Samuel F., Jr.	A	San Antonio	
115. Ponder, Stewart M.	A	San Antonio	
116. Ritch, Allen	A	San Antonio	
117. Timmins, Oliver H., Jr.	A	San Antonio	
118. Tritt, Earl F.	A	San Antonio	
119. Worsham, John W.	A	San Antonio	
Brown-Comanche-Mills-San Saba Counties			
13. McDaniel, MacField	A	May	Apr., 1946
Cameron-Willacy Counties			
13. Merrill, Samuel J.	A	Brownsville	
Cherokee County			
5. Boyd, James T.	A	Jacksonville	
Clay-Montague-Wise Counties			
3. Major, Robert A.	A	Bowie	
Collin County			
6. Wysong, Charley E.	A	McKinney	
Crane-Upton-Reagan Counties			
1. Cooper, William H.	A	McCamey	
Dallas County			
163. Burgess, George A.	A	Dallas	
164. Bush, Walter H.	A	Dallas	
165. Grafton, Edwin G., Jr.	A	Dallas	
166. Guller, Emanuel J.	A	Dallas	
167. Halpern, Salmon R.	A	Dallas	May, 1946
168. Harper, Robert W.	A	Dallas	
169. Hartin, Richard B.	A	Dallas	
170. Hodges, Harold C.	A	Dallas	
171. Knight, Marvin P.	A	Dallas	
172. Lee, Ridings E.	A	Dallas	
173. LoBello, Leon C.	A	Dallas	
174. McClellan, William W.	A	Dallas	
175. Mohle, Chester L.	A	Dallas	
176. Upshaw, Jackson E.	A	Dallas	
177. Vassallo, Harry R.	A	Dallas	
Dawson-Lynn-Terry-Gaines-Yoakum Counties			
7. Standifer, Lilburn E.	A	Lamesa[2]	
Denton County			
6. Cox, Joseph M.	A	Denton	
Eastland-Callahan Counties			
4. Harris, Calvin W.	A	Ranger	July, 1946
5. Watkins, Wirter P.	A	Eastland[3]	Mar., 1946
Ector-Midland-Martin-Howard-Andrews-Glasscock Counties			
11. Absher, L. Alton	A	Midland	Apr., 1946
El Paso County			
43. Cameron, David M.	A	El Paso	June, 1946
44. Cuen, M. J.	A	El Paso[4]	
45. Galatzan, Joe S.	A	El Paso[5]	Dec., 1945
46. Gallagher, Paul	A	El Paso	
47. Gardner, Wray R.	A	El Paso	
El Paso County—Continued			
48. Glasier, W. A.	A	El Paso[1]	
49. Hughes, Raymond P.	A	El Paso	
50. McMahan, George T.	A	El Paso[2]	
51. Tubbs, W. M.	A	El Paso[3]	
Falls County			
6. Brown, James M.	A	Marlin	Apr., 1946
Fannin County			
7. Stafford, F. B.	N	Trenton[4]	
8. Stevens, Joe L.	A	Bonham[5]	May, 1946
Galveston County			
44. Koch, Calvin O.	A	Galveston	
45. Parker, Charles A.	A	Galveston	
46. Reed, Roy G.	A	Lamarque[6]	May, 1946
47. Schubert, Herbert A.	A	Galveston	
Gray-Wheeler Counties			
5. McDaniel, Roy		Pampa	
6. Zeigler, Paul	A	Shamrock	
Grayson County			
12. Etter, Edward F.	A	Sherman	
Hale-Floyd-Briscoe-Swisher Counties			
6. Gee, Kenneth J.	A	Tulia	
7. Mitchell, Robert H.	A	Plainview	
Hardeman-Cottle-Foard-Motley Counties			
1. Fish, John H.	A	Paducah	
2. Sitta, Raymond E.	A	Chillicothe[7]	June, 1946
Hardin-Tyler Counties			
2. Dickerson, Joe W.	A	Rockland	
Harris County			
220. Arnold, Jasper H.	A	Houston	
221. Braden, Albert H.	A	Houston	
222. Harris, Herbert H.	A	Houston	
223. Jones, Joseph R.	A	Houston	
224. Kaminsky, Dave	N	Houston	June, 1946
225. Mitchell, A. Lane	N	Houston	
226. Orman, Forrest C.	A	Houston	
227. Parrish, Frank F.	A	Houston	
228. Paton, Donald M.	A	Houston	Mar., 1946
229. Slataper, Eugene L., Jr.	A	Houston	
Harrison County			
8. Carter, Ray H.	A	Marshall	
9. Payne, John E., Jr.	A	Marshall	
Hidalgo-Starr Counties			
10. Casey, John B.	A	McAllen	
11. Solis, Rene A.	A	Rio Grande City	
Hopkins-Franklin Counties			
4. Stevens, Thomas H.	A	Sulphur Springs	
Hunt-Rockwall-Rains Counties			
12. Dickens, William M.	A	Greenville	
Hutchinson-Carson Counties			
2. Wallace, Henry G.	A	Borger	
Jasper-Newton Counties			
7. Kaufman, Carl K.	A	Jasper	
Jefferson County			
49. Allison, F. Peel	A	Beaumont	May, 1946
50. Tyner, Furman H.	A	Port Arthur	
Johnson County			
5. Altaras, Leon M.	A	Cleburne	
Kaufman County			
6. Livingston, Edward N.	A	Terrell	
Kerr-Kendall-Gillespie-Bandera Counties			
9. Jones, Charles C., Jr.	A	Kerrville	
10. Powers, Harry J.	A	Legion	
11. Zeritsky, Samuel A.	A	Legion	
Lamar County			
7. Townsend, Courtney M.	A	Paris	
8. Woodfin, George S.	A	Paris	
Lampasas-Burnet-Llano Counties			
3. Hoerster, Henry J.	A	Llano	
Lubbock-Crosby Counties			
20. Loveless, James E.	A	Slaton	
McLennan County			
31. Brannon, E. P.	A	McGregor	June, 1946
32. Bullard, Ray E.	A	Waco	
33. Connally, H. Frank, Jr.	A	Waco	
34. Lauck, Robert E., Jr.	A	Waco	
35. Poore, Alfred M.	A	Waco	
36. Russo, Emilio N.	A	Waco	
37. Scanio, Thomas J.	A	Waco	Apr., 1946

*EDITOR'S NOTE: This list is the tenth of a series in which it is hoped to name all those physicians who have been in the Armed Forces during the war just passed and have now returned to Texas to resume civilian practice. The information in this list has been assembled from a variety of sources. While an attempt has been made to secure as complete and as accurate data as possible, we are aware that omissions and errors have been made. Not only for publication in the JOURNAL but also for the permanent records in the central office of the State Medical Association, we invite and urge correction of and addition to the material here submitted. Note that physicians from each county area are numbered consecutively following those listed in the July JOURNAL; the last number in each section therefore indicates the total physicians returned to that county area. The complete total for Texas named to date (July 25), including the accompanying list, is 1,499.

†A=Army; N=Navy; U=U. S. Public Health Service.
[1]Formerly of Midland.
[2]Formerly of Austin.
[3]Formerly of Dallas.
[4]Formerly of Ysleta.
[5]Formerly of Silver City.

[1]Formerly of Carlsbad.
[2]Formerly of Dallas.
[3]Formerly of Silver City.
[4]Formerly of Leonard.
[5]Formerly of Leonard.
[6]Formerly of Cameron.
[7]Formerly of Rosenberg.

NAME	Serv.†	Location	Release Date
Medina-Uvalde-Maverick-Val Verde-Edwards-Real-Kinney-Terrell-Zavala Counties			
6. Bourdon, Evan C.	A	Uvalde	
7. Guice, LeRoy E.	A	Sabinal	Feb., 1946
Montgomery County			
1. Bellnoski, William O., Jr.	A	Willis	
2. Shapiro, Jake	A	Conroe	
Nolan-Fisher-Mitchell Counties			
9. Wilkinson, Robert T.	A	Rotan	
Nueces County			
30. Gray, Paul M.	A	Corpus Christi	
31. Grossman, Bernard B.	A	Corpus Christi	
32. Grossman, David N.	A	Corpus Christi	
33. Knapp, Roger S.	N	Corpus Christi[1]	
34. Swearingen, Robert G.	A	Corpus Christi	
Orange County			
2. Barclay, L. H.		Orange[2]	
Palo Pinto-Parker Counties			
10. McCloud, Ben L., Jr.	A	Mineral Wells[3]	
Polk-San Jacinto Counties			
2. Berton, F. Frink	A	Corrigan	
Potter County			
28. Carroll, James R.		Amarillo	
Runnels County			
3. Rives, C. T.	A	Winters	Apr., 1946
Rusk County			
9. Suehs, Herbert A.	A	Henderson	
San Patricio-Aransas-Refugio Counties			
8. Tasch, Aloysius F.	A	Taft	
Scurry-Dickens-Kent-Garza-Borden-King-Stonewall Counties			
6. Howle, Thomas M.	A	Snyder	
7. Redwine, Harry P.	A	Snyder	
Shelby-San Augustine-Sabine Counties			
5. Bennett, Noel T.	A	San Augustine	

[1]Formerly of Aransas Pass.
[2]Formerly of Houston County.
[3]Formerly of Graford.

NAME	Serv.†	Location	Release Date
Smith County			
11. Golenternek, Joe	A	Tyler	
Tarrant County			
75. Hall, Ewin P., Jr.,	A	Fort Worth	
76. Howell, William L.	A	Fort Worth	
77. Lightbody, Kenneth A.	A	Fort Worth	
78. Wilson, Stephen W.	A	Fort Worth[1]	
Titus County			
2. Caldwell, Pearson C.	A	Mount Pleasant	
Tom Green-Coke-Crockett-Concho-Irion-Sterling-Sutton-Schleicher Counties			
13. Byars, Perry J. C.	A	San Angelo[2]	Feb., 1946
14. Nibling, Boyd	A	San Angelo[3]	
15. Wall, D. D.	A	San Angelo	
Travis County			
41. Davis, Nathan	A	Austin	
42. Rabb, Virg S., Jr.	A	Austin	
43. Ravel, Jerome	A	Austin	
44. Wilborn, Sam W.	A	Austin	
Upshur County			
1. Fenlaw, Joseph L.	A	Gilmer	Jan., 1946
Victoria-Calhoun-Goliad Counties			
3. Hartwick, Fred W.	A	Victoria	
4. Lester, Stanley W.	A	Port Lavaca	Feb., 1946
5. Smith, David H.	A	Victoria	
Washington County			
4. Hansen, Carl M.	A	Washington	
Wharton-Jackson-Matagorda-Fort Bend Counties			
11. Sanford, E. B.	A	Palacios[4]	June, 1946
Wichita County			
20. Harrison, W. T.	N	Electra	
21. Huff, Mark E.	A	Wichita Falls	
22. Humphrey, Irving L.	A	Wichita Falls	
23. Simmons, Lillard N.	A	Wichita Falls	
Wood County			
2. Matthews, Choice B.	A	Alba[5]	
Young-Jack-Archer Counties			
9. Hunt, Walter E.	A	Graham	

[1]Formerly of Linden.
[2]Formerly of Galveston.
[3]Formerly of Beaumont.
[4]Formerly of Port Arthur.
[5]Formerly of Houston.

INCREASE IN HOSPITAL ADMISSIONS

During 1945 one patient was admitted to a hospital in the continental United States every 1.9 seconds and a live baby was born in a hospital every 16 seconds, according to the 25th annual report of the Council on Medical Education and Hospitals of the American Medical Association.

F. H. Arestad, M. D., and M. G. Westmoreland, M. D., present the Council report in the April 20 issue of *The Journal of the American Medical Association*. Their figures reveal that in comparison with 1944 the number of hospital beds has increased from 1,729,945 to 1,738,944, the number of admissions from 16,036,848 to 16,257,402, the number of patient days from 475,607,484 to 512,915,155 and the number of hospital births from 1,919,976 to 1,969,667.

Represented in the report are 6,511 hospitals registered by the American Medical Association, including 1,156 hospitals approved for internships and residencies and 2,625 accredited by the American College of Surgeons as meeting unconditionally its minimum requirements for general standardization. The number of hospitals totals 100 less than reported in 1944.

Both governmental and nongovernmental hospitals showed a slight increase in bed capacity last year, the governmental group reporting 1,356,718 or 78 per cent of all beds, the nongovernmental hospitals 382,226 or 22 per cent. The federal hospitals which expanded rapidly during the war had a net loss of 4,751 beds compared with 1944.

In the present survey the general hospitals reported 922,549 beds as compared with 925,818 in 1944. This represents a net decrease of 3,269 whereas the previous year showed an increase of 75,242. With their present facilities the general hospitals have 53 per cent of all beds.

There were 16,257,402 admissions exclusive of outpatients and newborn infants in 1945. This is equivalent to 12.3 per cent of the total population according to the U. S. Census of 1940. Since 1935 the admissions in the hospitals registered by the American Medical Association have more than doubled in number. The greatest annual gain occurred in 1943 when an increase of 2,829,088 was reported. The following year showed an increase of 662,150 while the present survey indicates a net gain of 220,554 in comparison with 1944.

The governmental hospitals with 78 per cent of the bed capacity reported 6,399,113 admissions or 39 per cent of the patients admitted in 1945. The nongovernmental hospitals which received 61 per cent had 9,858,289. Both groups showed a substantial increase in hospital admissions in 1944 but in the present survey the governmental hospitals showed a net loss of 146,107 as compared with the previous year.

General hospitals supply the greatest volume of hospital service in the United States. Last year they admitted 15,228,270 patients—93.6 per cent of all admissions—and maintained an average daily patient load of 665,105. In addition they gave care to 1,907,772 newborn infants, 96.8 per cent of all live births reported in the registered hospitals in 1945. The nongovernmental general hospitals had a total of 9,371,874 admissions, the federal general hospitals 3,898,995 and the other governmental general hospitals 1,957,401.

The mental hospitals with 37.7 per cent of all beds had 248,876 admissions or only 1.5 per cent of the total patients admitted in 1945. In comparison

with 1944 there was an increased number of mental patients admitted in all nongovernmental groups. The mental hospitals under state, county and municipal control showed a slight decrease, but the federal division reported an increase of 13,147. The total gain in relation to the previous year was 22,483.

The tuberculosis sanatoriums showed a continued decrease in the number of patients admitted as evidenced by the present report of 86,186 admissions as compared with 88,281 in 1944.

The enormous volume of service rendered by hospitals in the United States is likewise reflected in the daily patient load, which averaged 1,405,247 in 1945 exclusive of newborn infants. For the first time also the daily census in general hospitals exceeded the patient load of the mental institutions, the latter reporting an average of 624,349 as compared with 665,105 in the general hospital section. In the previous year the corresponding figures were 618,951 and 570,331 respectively.

For the period represented in this report the registered hospitals in the United States had 13.2 beds per 1,000 population. The actual utilization of hospital beds, however, as determined in relation to the average daily census, was 10.6 beds per 1,000 population.

The governmental hospitals reported 315,149 births in 1945, the church related hospitals 665,153, the other nonprofit associations 793,220 and the proprietary institutions 196,145. The comparative figures for 1944 were 293,424, 652,761, 773,489 and 200,302 respectively. Last year the increase in hospital births was 49,691 whereas the previous year showed a decrease of 4,615. In 1942 and 1943, however, increases of 265,659 and 253,992 were reported.

Registered hospitals reported employing 144,724 graduate nurses exclusive of 25,277 private duty nurses during the latter part of 1945. The corresponding figures for 1944 were 125,458 and 23,949.

In connection with the present survey, state accredited schools of nursing reported a student enrollment of 130,909 as compared with 129,879 in 1944 and 110,222 in 1943.

EXERCISE FOLLOWING HIGH BLOOD PRESSURE SURGERY

Two New York physicians—Jere W. Lord, Jr., and J. William Hinton—advocate early exercise for patients after they undergo operations for relief of high blood pressure.

Physicians heretofore have generally prescribed bed rest following such operations, but the New York doctors, after carrying out tests on 30 consecutive patients, now believe that exercise is more helpful than bed rest in keeping down blood pressure.

Their study, reported in the December 22 issue of *The Journal of the American Medical Association*, showed that exercise after surgery caused no significant change in the level of the blood pressure.

The blood pressure readings were taken with the patient in different positions—lying down, sitting, and standing. Then the pressure was taken again after the patient exercised by stepping up and down onto a low foot stool, first with one leg and then with the other for 20 times in all.

The New York doctors cite the case of one patient, a man 42, who was suffering from malignant hypertension. The resting blood pressure of 280/180 rose to 300/195 following exercise. One month after he underwent surgery on the sympathetic nervous system, his resting level was 145/125, which after exercise fell to 110/100. Three months later, the patient's resting blood pressure was 130/80.

"In the series of 30 patients," the doctors wrote, "the average postoperative fall in the resting diastolic blood pressure was 15 millimeters (mercury instrument). However, when the preoperative and postoperative diastolic levels following exercise were compared, an average fall of 32 millimeters was observed."

HOSPITALS NEEDING INTERNS AND RESIDENTS

Methodist Hospital, Dallas. Capacity 206 beds. C. B. Fielder, Superintendent (interns desired, July, 1947).

El Paso City County Hospital, El Paso. Capacity 192 beds. George W. Cook, Col., U. S. A., Ret., Superintendent (3 interns for one year term, graduates of class A medical school only).

PHYSICAL REHABILITATION CENTERS

The need for additional rehabilitation services and centers where the disabled and handicapped can receive post-hospital physical rehabilitation, psychosocial adjustment, and vocational guidance and retraining is stressed in the final report of the subcommittee on civilian rehabilitation centers issued recently by the Baruch Committee on Physical Medicine.

The report, prepared by a group of six authorities with military and civilian rehabilitation experience, blueprints the organization and operation of model community rehabilitation centers. Emphasizing that such centers should integrate rather than duplicate the work of existing agencies, it outlines the organization and operation of proposed centers which would offer physical medicine (physical therapy, occupational therapy, physical rehabilitation), psycho-social adjustment, vocational guidance, social service, vocational education, special education for the handicapped, a sheltered workshop, brace and limb shop, research in rehabilitation, and an industrial program for the homebound.

The centers would not provide definitive medical treatment, but would bridge the gap between the bed and the job by following preventive and curative medicine and surgery with what the committee terms "the third phase of medical care."

The report suggests that the envisioned centers might be established by communities as "living war memorials" by the action of local governments, civic groups, social agencies, or medical schools and hospitals. They point out that both the construction and operating costs of such centers would be considerably less than for hospitals and would release needed hospital beds for sick patients.

In addition to large highly specialized urban centers, the report stresses the need for a system of mobile consultant clinics comparable to those which have been used in the cancer and crippled children's programs in order to carry opportunity to the isolated, disabled person.

EFFECTIVE VACCINE AGAINST DENGUE FEVER

An effective vaccine has been obtained against dengue fever, it was announced recently by the Commission on Neurotropic Virus Diseases of the Army Epidemiological Board.

This malady, which occurs in epidemics and sometimes pandemics through the warmer portions of the temperate zone, is due to a filtrable virus. It is characterized by an intermittent fever, rash on the skin, and often excruciating pains in the joints. The name has been identified with the Spanish "dengue," meaning "stiffness or primness," and is supposedly descriptive of the curious cramped movements of a sufferer.

The virus first was isolated in Hawaii by army doctors and brought to the United States where it has undergone thirty-two consecutive passages through the brains of mice. In the course of these passages it underwent a curious mutation, whereby it has lost its capacity to produce in men the severe illness and protracted fever characteristic of the

original disease. It has retained, however, its ability to produce the measles-like rash and it gives subsequent immunity to the unmodified dengue virus. The immunizing dose is very small. The extract from the brain of a single mouse has been found to contain at least 10,000 such doses. The new vaccine is prepared from this modified virus.

There remains the possibility that there may be several strains of the dengue virus—as is known to be the case for several other viruses, such as that which causes influenza. However, two additional virus samples brought from India have been found immunologically identical with the original Hawaiian strain. Repeated attempts have been made to isolate still another strain by inoculating volunteer human subjects with sera obtained in the Philippines and Okinawa during apparent dengue outbreaks. These have been unsuccessful.

It also has been found possible to propagate in chick embryos the dengue virus after about eighteen passages through mouse brains.

Two strains of alleged dengue virus obtained from Japan have been found quite different from the Hawaiian and Indian strains—different, in fact, from any other known virus.—S. G. O. Notes, May 15, 1946.

NEED OF BARBITURIC LEGISLATION

Fourteen states and the District of Columbia at present have no law regulating the sale and distribution of barbiturates, commonly known as sleeping pills, according to the December 29 issue of *The Journal of the American Medical Association.*

At a recent conference of various groups and government agencies, sponsored by the Committee on Legislation of the American Pharmaceutical Association, the problem came up for study because even the states that do provide laws for the control of this drug are lax in enforcing them.

The Journal said editorially:

"Discussion was held on barbiturate regulation, barbiturate habituation and tolerance, and the medical, pharmaceutical and legal aspects of the problem. At this time fourteen states and the District of Columbia have no law regulating the sale and distribution of barbiturates. The laws in the other states are not uniform and have been subjected to much abuse. Today many people are aware of the action of this group of drugs; accidental deaths, suicides and ill health directly attributable to the effect of the drugs are on the increase. Careless prescribing, direct sales to the consumer, and 'bootleg' distribution have aided those who are determined to get the drug. Some have proposed the adoption of a federal law which would regulate the distribution of barbiturates much as opium derivatives are now controlled. More are in favor of control on the state level, particularly if a uniform state act can be formulated and adopted."

SALICYLIC ACID IN RHEUMATIC FEVER

Rheumatic fever infection has been effectively suppressed in a group of patients treated with small doses of a powerful and poisonous drug called salicylic acid during the acute phase of the disease, according to Comdr. R. C. Manchester, M. C., U. S. N. R. The report appears in the May 18 issue of *The Journal of the American Medical Association.*

Rheumatic fever is a disease which may recur often causing permanent damage to the heart. It is the most frequent cause of heart disease in persons under middle age. The bacteria hemolytic streptococci are believed to be the accessories, if not the cause, of rheumatic fever.

Fifty-four enlisted naval men afflicted with acute rheumatic fever were treated with salicylates. Two methods were employed—injections into the veins and administration by mouth. The drug was given in conjunction with sodium bicarbonate to neutralize the gastric acid, since it is not well tolerated alone by the stomach.

Thirty-five of the patients received injections of 10 mg. of the salicylate daily from four to ten days and then were given the drug by mouth. The other 19 received the drug by mouth only. The author states that treatment by injection is more effective in alleviating the acute manifestations, such as fever and pain. However, taken by mouth daily, the drug satisfactorily suppresses rheumatic infection.

Some of the mild reactions noted by the author were nausea, vomiting, deafness, ringing sound in the ears, dizziness, and sweating. Serious reactions which interrupted treatment were delirium, labored breathing, excessive vomiting, pain, and skin eruptions.

Severe delirium was observed in 17 per cent of the 35 patients who received injections of the drug. Also known as "acute salicylism," the condition is most likely to occur in acutely ill patients who have not built up tolerance to the drug before treatment begins. Because the injection method is the more desirable form of treatment in the acute cases, the delirium is not preventable in all instances. Such patients must be carefully observed for the first signs of mental confusion so that the medication can be promptly discontinued before severe delirium occurs.

The author suggests that the salicylate treatment be continued until the sedimentation rate of the red blood cells has remained normal for two weeks. This is determined by timing the rate at which red blood cells drop to the bottom of a test tube. While the disease is in its active stage the sedimentation rate is high. It declines as the infection subsides; therefore it is a very useful method of checking on the patient's progress.

A. M. A. COUNCIL REPORTS

COUNCIL ON PHARMACY AND CHEMISTRY

Potencies of Vitamin A Preparations Accepted by the Council

The Council has authorized publication of the following statement.

Austin Smith, M. D., *Secretary.*

From time to time the Council office has received inquiries from manufacturers as to the acceptability of vitamin A preparations in dosages of potency ranging from 50,000 units to 150,000 units or more. The Council has previously accepted no dosage of potency higher than 25,000 units. The Council believes that this policy should be continued. In reaching this conclusion, the Council is not concerned with toxic effects of vitamin A from the administration of capsules of higher potency. This view is based on the fact that to encourage the use of very large doses of vitamin A would not be in the interest of good medical practice. If those interested in doing investigational work desire to experiment with daily dosages of the order of 50,000 to 150,000 or more units they may use multiples of a 25,000 unit dosage. The Council finds no justification for routine administration of doses in excess of 25,000 units per day.

COUNCIL ON INDUSTRIAL HEALTH AND COUNCIL ON PHARMACY AND CHEMISTRY

Aluminum in the Prevention and Treatment of Silicosis

The Council on Industrial Health and the Council on Pharmacy and Chemistry of the American Med-

ical Association have authorized publication of the following report on the use of aluminum in the prevention and treatment of silicosis. Since this means of therapy is controlled by patent and can be used only by licensees, studies will be continued by the two councils into this phase of the subject. Further reports will be issued as indicated.

CARL M. PETERSON, M. D.,
Secretary, Council on Industrial Health.
AUSTIN E. SMITH, M. D.,
Secretary, Council on Pharmacy and Chemistry.

The dissemination of reports on the effects of aluminum powder in the prevention and treatment of silicosis has aroused widespread interest and a demand for an authoritative statement regarding its value. At the present time the following statement would seem to be warranted; it is subject, however, to such modification as future knowledge and experience may indicate.

1. In experimental animals the *prophylactic* use of aluminum inhibits the toxic action of relatively pure quartz.

2. In man, industrial dust exposures often involve mixtures of various minerals in addition to quartz and other environmental variables to which experimental animals are not subject. Therefore human silicosis usually develops more slowly and is often modified in type. Only prolonged unbiased observation, with adequate control cases, will demonstrate whether the prophylactic results obtained with animals are applicable to man.

3. Animal experiments have demonstrated that administration of high concentrations of amorphous hydrated alumina unfavorably influences resistance to tuberculosis. While this result has not yet been reported for metallic aluminum, caution in the application of all aluminum therapy to human beings is recommended.

4. The use of aluminum might appear as an easy short-cut to healthful working conditions, thus saving large expenditures for ventilation and other control methods. Actually there is no substitute for the accepted methods of dust control.

5. If industry indiscriminately treats all employees with aluminum dust, there may be aggravation of tuberculosis or other pulmonary conditions.

6. The *therapeutic* use of aluminum in man appears to relieve symptoms in a very small number of cases in which silicosis develops rapidly. Experience in some groups is more favorable than in others.

7. In view of these considerations it is recommended that the general application of aluminum therapy in industry be delayed until adequately and impartially controlled clinical observation demonstrates its effectiveness in preventing or alleviating silicosis in man. In the meantime, there should be no slackening in the control measures that have been found effective in reducing the incidence of dust diseases in industry.

—J. A. M. A., May 11, 1946.

COUNCIL ON FOODS AND NUTRITION

ACCEPTED FOODS

The following additional foods have been accepted as conforming to the Rules of the Council on Foods and Nutrition of the American Medical Association for admission to Accepted Foods.

JAMES R. WILSON, M. D., *Secretary.*

Preparations Used in the Feeding of Infants (See Accepted Foods, 1939, p. 156).

SWIFT & COMPANY, CHICAGO

Swift's Meats for Juniors, including Diced Beef, Diced Pork, Diced Lamb, Diced Veal, Diced Beef Liver and Diced Calf Heart, are made from meats trimmed of fat, sinews and connective sheaths with added salt, prepared under inspection of the Meat Inspection Division of the United States Department of Agriculture.

Analysis (submitted by manufacturer).—

	Moisture, %	Protein, %	Fat, %	Ash, %
Diced beef	74.7	22.63	1.70	1.47
Diced pork	70.7	21.81	6.48	1.51
Diced lamb	74.3	18.19	6.3	1.41
Diced veal	76.7	20.38	2.1	1.52
Diced beef liver	70.2	21.56	4.33	1.68
Diced calf heart	76.3	18.19	3.35	1.44

Mineral Components:

	NaCl, %	Calcium, Mg./100 Gm.	Phosphorus, Mg./100 Gm.	Iron, Mg./100 Gm.
Diced beef	0.47	10	210	3.3
Diced pork	0.48	14	200	1.5
Diced lamb	0.53	18	180	2.4
Diced veal	0.47	11	210	1.6
Diced beef liver	0.48	30	330	7.2
Diced calf heart	0.41	15	220	4.8

Vitamins:

	Thiamine, Mg./100 Gm.	Riboflavin, Mg./100 Gm.	Niacin, Mg./100 Gm.
Diced beef	0.017	0.326	4.68
Diced pork	0.452	0.238	3.74
Diced lamb	0.042	0.287	5.33
Diced veal	0.052	0.350	6.28
Diced beef liver	0.03	2.200	7.10
Diced calf heart	0.156	1.067	4.44

Total Calories:

Diced beef	1.05 per gram
Diced pork	1.45 per gram
Diced lamb	1.30 per gram
Diced veal	1.00 per gram
Diced beef liver	1.25 per gram
Diced calf heart	1.03 per gram

Swift's Meats for Babies, including Strained Beef, Strained Pork, Strained Lamb, Strained Veal, Strained Beef Liver and Strained Calf Heart, are made from meats trimmed of fat, sinews and connective sheaths with added broth and salt and are prepared under inspection of the Meat Inspection Division of the United States Department of Agriculture.

Analysis (submitted by manufacturer).—

	Moisture, %	Protein, %	Fat, %	Ash, %
Strained beef	78.6	17.69	3.01	1.21
Strained pork	75.0	17.06	6.04	1.15
Strained lamb	79.0	15.63	4.48	1.32
Strained veal	82.1	16.38	1.04	1.19
Strained beef liver	78.2	15.94	4.26	1.22
Strained calf heart	82.7	13.38	2.51	1.20

Mineral Components:

	NaCl, %	Calcium, Mg./100 Gm.	Phosphorus, Mg./100 Gm.	Iron, Mg./100 Gm.
Strained beef	0.30	12	140	2.8
Strained pork	0.38	14	180	1.7
Strained lamb	0.45	16	170	2.3
Strained veal	0.38	17	180	1.6
Strained beef liver	0.53	40	270	7.7
Strained calf heart	0.30	12	150	3.6

Vitamins:

	Thiamine, Mg./100 Gm.	Riboflavin, Mg./100 Gm.	Niacin, Mg./100 Gm.
Strained beef	0.010	0.242	3.24
Strained pork	0.346	0.278	4.74
Strained lamb	0.026	0.264	4.00
Strained veal	0.024	0.288	4.90
Strained beef liver	0.014	2.00	4.41
Strained calf heart	0.064	0.818	4.46

Total Calories:

Strained beef	0.98 per gram
Strained pork	1.22 per gram
Strained lamb	1.03 per gram
Strained veal	0.75 per gram
Strained beef liver	1.02 per gram
Strained calf heart	0.27 per gram

—J. A. M. A., April 6, 1946.

LIBRARY NOTES

The package library consists of collections of reprints and other periodical material on various subjects, prepared for lending to members of the Association. Requests for packages should be addressed "Library, State Medical Association of Texas, 1404 W. El Paso Street, Fort Worth, Texas." Twenty-five cents in stamps should be enclosed with the request to cover postage and part of the expense of collecting the material. Only one package may be borrowed at a time, and packages are allowed to remain in the hands of the borrower for 14 days.

Package Service

Packages were mailed from the Library of the State Medical Association during July, to the following:

Dr. Everett C. Fox, Dallas—*Skin, diseases* (26 articles).

Dr. T. G. Brown, Dumas—*Alcoholism, therapy* (27 articles).

Dr. J. D. Magee, Abilene—*Globus Hystericus* (4 articles); *Eyes, foreign bodies* (8 articles); *Cataract, extraction* (16 articles); *Eyelids, surgery* (7 articles); *Fistula, oroantral* (5 articles).

Dr. L. J. Webster, Abilene—*Anemia* (34 articles).

Dr. Holloway Bush, McKinney—*Syphilis, therapy* (34 articles).

Dr. D. C. Enloe, Sherman—*Pylorus, hypertrophy and stenosis* (12 articles).

Dr. M. L. Stubblefield, Baird—*Blood, groups* (24 articles).

Dr. Victor E. Schulze, San Angelo—*Rickettsia* (10 articles).

Dr. Charles Mims, Mission—*Presbyopia* (6 articles); *Bile Ducts, obstruction* (8 articles); *Conjunctivitis* (23 articles).

Dr. T. L. Denson, Cameron—(2 journals).

Dr. A. J. McNeill, Dallas—(1 journal).

Dr. C. E. Webb, El Paso—*Varicose Veins* (30 articles).

Dr. F. C. Feener, El Paso—(4 reprints, 2 journals).

Dr. O. R. Hand, Lubbock—*Blood, groups* (10 articles).

Medical Library, Veterans Administration, McKinney—(1 journal).

Dr. Herbert J. Bell, El Paso—*Coccidioidosis* (18 articles).

Medical Library, Providence Hospital, Waco—*Gout* (20 articles).

Dr. Charles H. Brown, Wichita Falls—*Poliomyelitis* (23 articles).

Dr. C. R. Finnegan, Dallas—*Jaundice* (24 articles).

Dr. Aubrey L. Lewis, San Angelo—(1 journal).

Dr. Mildred V. Hanna, Glen Rose—*Poliomyelitis* (7 articles).

Dr. Robert L. Dailey, Wichita Falls—*Pericarditis, with effusion* (12 articles); *Sclerosis, disseminated* (15 articles).

Dr. Stanley L. Clayton, Hallettsville—(1 journal).

Dr. J. D. O'Brien, Dallas—*Blood Pressure, High, therapy* (8 articles).

Dr. Heinrich Lamm, La Feria—*Tonsillectomy* (2 articles).

Dr. W. R. Klingensmith, Amarillo—(1 journal).

Dr. Frank C. Hodges, Abilene—*Fractures, therapy* (1 article).

Dr. Hervey W. Dietrich, El Paso—(4 journals).

Dr. C. C. McDonald, Tyler—*Tuberculosis* (8 articles).

Dr. Allan Shields, Victoria—*Roentgenotherapy* (20 articles).

Dr. M. C. Carlisle, Waco—*Brucellosis* (28 articles).

Dr. Leo J. Peters, Jr., Orange—*Appendicitis, traumatic* (8 articles).

Dr. U. S. Marshall, Roswell, N. M.—*Rheumatism* (15 articles).

Dr. Samuel W. Shibler, Temple—*Parathyroid, diseases* (9 articles).

Miss Lillian Overton, Cuero—*Hospitals, administration and organization* (19 articles).

Dr. E. D. McDonald, Santa Anna—*Thyroid, hyperthyroidism* (13 articles).

Mr. D. G. Burk, Big Spring—*Hospitals, administration and organization* (20 articles).

Dr. I. H. Mannheimer, Seguin—*Pelvis, measurement* (14 articles).

Accessions

Chicago, Year Book Publishers—Wiener, Editor: Ophthalmology in the War Years.

Philadelphia, W. B. Saunders Company—Allen, Barker and Hines: Peripheral Vascular Diseases.

Washington, National Research Council—Hawkins, Editor: Scientific, Medical and Technical Books.

Summary

Reprints received, 550.	Local users, 28.
Journals received, 219.	Borrowers by mail, 38.
Items cousulted, 74.	Packages mailed, 46.
Items taken out, 167.	Items mailed, 552.

Total items consulted and mailed, 793.

MOTION PICTURE FILM LIBRARY

Motion picture films on medical subjects, 16 mm., both silent and sound, some in color, and suitable for either medical or lay audiences, are available for loan to county medical societies, hospital staffs, or individual physicians, on request. Borrowers will be required to pay only the cost of shipment of the films, by express, with insurance, and for any damage to films while in the hands of the borrower.

Requests for films should be addressed to "Motion Picture Film Library, State Medical Association of Texas, 1404 West El Paso Street, Fort Worth 3, Texas." A list of available films, with descriptions, will be furnished on request.

The following motion picture films were loaned by the Motion Picture Lending Library of the State Medical Association during July:

From Moo to You (Available through the courtesy of the Borden Company, New York)—The Mexican Baptist Church, Fort Worth.

Immunization (Available through the courtesy of Lederle Laboratories, Inc., New York)—Rotary Club and the Child Study Club, Ranger.

Vitamins and Some Deficiency Diseases (Available through the courtesy of Lederle Laboratories, Inc., New York)—Premedical students, Lamar College, Beaumont.

NEWS

Contributions to this department will be appreciated. News should be of general medical interest, such as public health activities, new hospitals, personal items of more than local value, etc. News for a particular number of the Journal should be in the hands of the Editor not later than the fifteenth of the preceding month.

The American College of Surgeons will meet December 16-20 at the Cleveland Public Auditorium, Cleveland, Ohio, instead of September 9-13 in New York, reports *The Journal of the American Medical Association.* The change in plans was necessitated because the United Nations Assembly caused a shortage of hotel accommodations in New York.

An East Texas Crippled Children's Clinic was held June 27 at Henderson under sponsorship of the Henderson Kiwanis Club, reports the Tyler *Telegraph.* Four Dallas physicians, Drs. Brandon Carrell, Ruth Jackson, Margaret Watkins, and P. M. Girard, conducted examinations. The crippled children's division of the Texas State Health Department also cooperated in making possible the free examinations. A similar clinic has been held annually in Henderson since 1933.

Health in Port Arthur was the general theme June

18 for the first in a series of public radio forums sponsored by the local Junior Chamber of Commerce, according to the Port Arthur *News*. Dr. L. C. Heare, chairman of the Chamber of Commerce health committee, called for greater efforts in cleaning up the community and complimented city and county health officers for their work. Dr. B. W. Wood, city health officer, discussed poliomyelitis conditions in Port Arthur. Dr. J. M. White, county health officer, urged the abolition of septic tanks and installation of a modern sewerage system in the interest of health.

A Latin-American Health Campaign directed particularly against tuberculosis was sponsored in Fort Worth the last week in June by the Fort Worth-Tarrant County Tuberculosis Society, the City Health Department, and a newly organized Latin-American Council. Ten community meetings were held and a radio talk was given. At a mass meeting Dr. John J. Andujar, Fort Worth physician, and R. C. Ortega, director of the Latin-American program of the Texas Tuberculosis Association, spoke in Spanish. Dr. Bert C. Ball, Fort Worth, represented the local tuberculosis society and spoke on the importance of mass radiography. A health film and musical entertainment completed the program. An exhibit on tuberculosis made by members of the Business and Professional Women's Club and Spanish posters made by commercial art students from the city schools were on display.

A Doctors' Office Building in Tyler to cost about $50,000 has been approved by city officials who issued a building permit to D. K. Caldwell, former Tyler city commissioner, states the Tyler *Telegraph*. Additions to and remodeling of a structure now at the location are under way, but delays in completing the proposed twenty-eight room structure were expected because of the scarcity of building materials.

The Veterans Administration Hospital at Temple, formerly McCloskey General Hospital, has been opened for medical and surgical patients, reports the Temple *Telegram*. Dr. Leroy M. Cochran, former manager of the Veterans Administration hospital in Amarillo, was assigned to put the 500-bed Temple hospital in operation. The area from which patients will be drawn will probably comprise most of central and south Texas.

Texas Medical Center.—An extensive survey to determine the hospital needs of the Houston area were begun the middle of July under sponsorship of the Texas Medical Center, informs the Houston *Post*. James A. Hamilton, New Haven, Conn., professor of hospital administration at Yale University and past president of the American Hospital Association, will make the three month study, the results of which will be available to interested agencies other than those of the Texas Medical Center. The survey is expected to make available information from numerous sources regarding the needs for medical and hospital service in Houston and suggestions for the type and proper distribution of facilities necessary to care for these needs. Dr. E. W. Bertner, president of the board of directors of the center, pointed out that such information should be of value to city and county health authorities and governments and already existing hospitals and welfare agencies as well as to those planning specifically for the dozen hospitals of the center.

University of Texas.—Dr. W. B. Sharp, professor of bacteriology at the University of Texas School of Medicine, was honored by the Bacteriology Club of the college with a dinner in June in recognition of his twenty-five years of continuous service to the medical college, states the Galveston *News*. Dr. Sharp reviewed the development of bacteriology during his association with the college. Dr. Chauncey D. Leake, vice-president and dean, also spoke.

Winthrop Chemical Company, Inc., has recently awarded two grants for the year 1945-1946 to the University of Texas Medical Branch for studies in anesthesia and a study of vitamins and diodrast. Dr. J. B. Rice, director of medical research for the company, has announced that grants totalling $92,500 have been made for special research by universities, hospitals, and foundations within the next year or two.

Southwestern Medical College.—Brig. Gen. William Lee Hart, U. S. A., Ret., on August 1 assumed the duties of dean of Southwestern Medical College, replacing Dr. Donald Slaughter, dean of students, who resigned to become dean of the University of South Dakota Medical School, and also taking over the administrative duties of Dr. Tinsley R. Harrison, who asked to be relieved as dean of faculty to devote his full time to research and teaching at the college. In announcing the selection of a new dean, Dr. E. H. Cary, president of Southwestern Medical Foundation, pointed to General Hart's accomplishments in the Army Medical Corps, of which he had been a member since 1908, for which he has been decorated by European and South American nations and was awarded the Founders Medal of the Association of Military Surgeons of the United States in 1942. General Hart, former medical director of the Eighth Service Command with headquarters in Dallas, was awarded the first honorary degree granted by Southwestern Medical College only last June, when he was presented with the degree of doctor of humanistic letters. Dr. William F. Mengert, professor and chairman of the department of obstetrics and gynecology, upon the request of the board of trustees, acted as dean of the college during July after Dr. Slaughter had left and before General Hart arrived.

Dr. Donald Slaughter, dean of Southwestern Medical College, who resigned to accept the deanship of the University of South Dakota Medical School, was honored at a luncheon sponsored by the board of trustees of the Southwestern Medical Foundation shortly before his departure July 1, reports the Dallas *Times-Herald*. Dr. Milford O. Rouse, president of the Dallas Southern Clinical Society and principal speaker, commended Dr. Slaughter on his accomplishments and his aid to medicine and medical research in the Southwest. Dr. Slaughter, coming to Southwestern Medical College in May, 1943, did much to organize and establish the new college, it was pointed out. Dr. E. H. Cary, president of the Southwestern Medical Foundation, also paid tribute to Dr. Slaughter's ability and achievements.

Enlargement of facilities and expansion of the research program for poliomyelitis and encephalitis were under way in July at Southwestern Medical College, informs the Dallas *Times-Herald*. Dr. S. Edward Sulkin, head of the bacteriology and immunology department, announced that quarters for two additional research assistants and space for more experimental animals were being added to the present building. He said that Ernest M. Izume, director of laboratory services at Fort Dix, N. J., and Miss Elizabeth Lee Watson, employed in the research laboratories of the New York City health department, are joining his research staff. The expanded program is being sponsored by a grant from the National Foundation for Infantile Paralysis.

Dr. Carl A. Moyer, for the past two years surgical director of a Michigan hospital and teacher of physiology, gross anatomy, and pharmacology at the University of Michigan, has joined the staff of Southwestern Medical College as professor of experimental surgery, reports the Dallas *Times-Herald*. He will also participate in the care of patients at Parkland Hospital. Dr. Moyer has done extensive research work in anesthesia and surgerv and is author of numerous scientific papers.

Personals

Dr. R. A. Miller, San Antonio, has recently been named vice-president of the American Society of Anesthesiologists, according to *The Journal of the American Medical Association.*

Dr. James T. Mills, chief surgeon of Baylor University Hospital, Dallas, has been elected vice-president of the American Association of Plastic Surgeons, reports the Dallas *News*. Dr. Mills is also professor of plastic surgery at Southwestern Medical College.

Dr. A. K. Doss, Fort Worth, presented a paper at the meeting July 22-25 of the American Urological Association in Cincinnati, informs *The Journal of the American Medical Association.*

Dr. C. M. Hendricks, El Paso, is the new president of the American College of Chest Physicians, having taken office at the San Francisco meeting June 27-30 after serving during the past year as president-elect. During the meeting of the College Dr. Hendricks also was active as chairman of the council on military affairs and public health.

Dr. J. W. Nixon, San Antonio, presented a paper before the American College of Chest Physicians in San Francisco on June 30.

Dr. Arild E. Hansen, professor of pediatrics at the University of Texas Medical Branch, was on the program of the American Academy of Applied Nutrition in San Francisco, June 28-29.

Dr. M. A. Biggers, Canyon, on June 14, celebrated his fiftieth anniversary as a licensed physician in Texas, informs the Canyon *News*. Dr. Biggers began practice in Mount Pleasant in 1896. He has practiced more than twenty-six years in and near Canyon.

Dr. Edward O. Deal, pioneer Irion County physician, was injured in an automobile collision in Mertzon on June 3, states the San Angelo *Standard-Times.*

Dr. J. W. Bass, Dallas health officer, has been requested by Washington officials to assist in writing a medical history of the war in the Southwest Pacific, reports the Canton *Herald.* Dr. Bass spent forty-four months in that area.

Dr. Ben Primer, director of the Austin-Travis County Health Unit, has been awarded the Army Commendation Ribbon for his service as chief of the Fourth Army headquarters preventive medicine sub-section from October 4, 1944, to August 25, 1945, states the Austin *American-Statesman.*

Dr. Noble H. Price, Lamesa, recently spent six weeks taking a special course in surgery at Rochester, Minn., according to the Lamesa *Courier. Dr. J. W. Sinclair*, Tahoka, was in charge of the Price Hospital during Dr. Price's absence.

Dr. Gordon Clark, Iowa Park, has been named by Wichita County commissioners to succeed *Dr. W. B. Dorbandt*, resigned, as a member of the Wichita General Hospital board, informs the Wichita Falls *Record-News.*

Dr. P. M. Payne, Asherton, has purchased the Faust Hotel at Comfort, states the Carrizo Springs *Javelin.* In addition to continuing operation of the property as a hotel, Dr. Payne will maintain an office for his medical practice in the building.

Dr. Russell S. Wolfe, Houston, has been appointed chief of medical service of the Southeast Texas region of the Veterans Administration, according to the Houston *Post.* Dr. Wolfe, a veteran of five years in the Army, will administer outpatient, mental hygiene, and dental services for the Houston region.

Marriages

Dr. E. M. Cowart and Miss Marcelle Smith were married in Houston on April 10.

Dr. Otto Roger Hollan, Sinton, married Miss Edith Ann Lingle, Lancaster, Pa., on April 23.

Dr. David W. Quick, Jr., Galveston, married Miss Elizabeth Du Bois, Spokane, Wash., on April 22.

Dr. Carroll T. Adriance and Miss Gloria Gene Kierbow, both of Galveston, were married February 3.

Dr. George L. Porter, Dallas, married Miss Adina Hintze, Philadelphia, Pa., at Waco on June 29.

SOCIETY NEWS

Brown-Comanche-Mills-San Saba Counties Society

June 10, 1946

Abdominal Wounds Seen on Duty with the Marine Corps in the South Pacific—John W. Tottenham, Jr., Fort Worth.

Brown-Comanche-Mills-San Saba Counties Medical Society held its annual spring barbecue at Lake Merritt near Goldthwaite on June 10. About sixty-five members, their families, and friends were present. President Homer B. Allen, Brownwood, presided.

John W. Tottenham, Jr., Fort Worth, a former resident of Brownwood, was the guest speaker. He based his discussion of abdominal wounds on the cases he had seen while serving with the Marine Corps in the South Pacific.

Another barbecue at the lake has been planned for September.

Dawson-Lynn-Terry-Gaines-Yoakum Counties Society

June 12, 1946

Coronary Diseases of the Heart—Floyd T. McIntire, San Angelo.
Surgical Techniques—Gordon F. Madding, San Angelo.

Dawson-Lynn-Terry-Gaines-Yoakum Counties Medical Society met at the Lamesa Country Club on June 12 for a chicken dinner with the auxiliary, followed by a scientific program presented by Floyd T. McIntire and Gordon F. Madding, both of San Angelo. A round table discussion was held following the presentation of the papers named above. About twenty members and guests were present.

Falls County Society

July 10, 1946

(Reported by J. W. Torbett, Sr., Secretary)

X-Ray Treatment of Tumors of Small Intestines—Robert D. Moreton, Temple.
Our Political Problems—H. R. Dudgeon, Waco.

Falls County Medical Society met July 10 in the Blue Room of the Falls Hotel, Marlin. Following dinner, which was served to members and their wives, the program given above was carried out under the direction of S. S. Munger, program chairman.

Gregg County Society

June 11, 1946

Control of Communicable Diseases—W. R. Ross, Tyler.

Gregg County Medical Society sponsored a mass meeting at Longview on June 11 for making plans for a county-wide clean-up campaign. The principal speaker was W. R. Ross, Tyler-Smith County Health Unit director, who discussed the control of communicable diseases, particularly poliomyelitis.

Jefferson County Society

July 2, 1946

(Reported by L. R. Byrd, Jr., Secretary)

Legislative Program of the State Medical Association—L. C. Powell, Beaumont.

Jefferson County Medical Society held a called meeting at Hotel Dieu, Beaumont, on July 2, with President George Sladczyk, Port Arthur, presiding.

L. C. Powell, Beaumont, designated by the Board of Trustees of the State Medical Association as a special speaker, spoke to the society on the legislative program of the Association, discussing the proposed basic science law and the need for full support by each county medical society of candidates for the Legislature who are qualified and have committed themselves to support the public health meas-

ures recommended by the State Medical Association. A discussion of the local situation was participated in by T. A. Fears and W. D. Brown, Beaumont, and L. C. Heare, Port Arthur.

Following the society meeting, the Board of Directors of Jefferson County Medical Society, with President Sladczyk presiding, heard a letter from Holman Taylor, Secretary of the State Medical Association, stating that the Judicial Council of the American Medical Association had upheld the decision of Jefferson County Medical Society in expelling one of its members. Dr. Powell, seconded by Dr. Heare, moved that the expelled doctor be notified of the decision and that hospitals of the county also be informed of the action. The motion carried.

Upon motion by J. C. Crager, Beaumont, seconded by Dr. Powell, the Board voted to renew a subscription to *The Journal of the American Medical Association* for Lamar College, Beaumont.

Morris Weiss, Beaumont, was elected to membership upon application, transferring from Cook County Medical Society, Illinois.

Dr. Sladczyk appointed H. E. Alexander, Beaumont, chairman; John A. Hart, Beaumont, and other members as necessary to be selected by the chairman, to a committee to advise with the Board of Trustees of the Baptist Hospital to be built in Beaumont. The committee was named at the request of the hospital board.

Randall-Deaf Smith-Parmer-Castro-Oldham Counties Society

July 3, 1946

(Reported by Robert P. Jarrett, Secretary)

Proposed Basic Science Law—A. E. Winsett, Amarillo.

Randall-Deaf Smith-Parmer-Castro-Oldham Counties Medical Society met at the Neblett Hospital, Canyon, on July 3. Decision was made that the group should continue as an individual society, and R. A. Neblett, Canyon, was elected temporary president and Robert P. Jarrett, Canyon, temporary secretary-treasurer. It was decided to meet at Hereford in August to elect permanent officers.

Six members and one prospective member heard A. E. Winsett, Amarillo, discuss the proposed basic science legislation advocated by the State Medical Association. The society agreed actively to support passage of the bill.

Members were urged to pay state dues immediately if they had not done so.

Tarrant County Society

June 18, 1946

(Reported by W. P. Higgins, Jr., Secretary)

Colostomy: Its Uses and Abuses—George R. Enloe, Fort Worth.

Tarrant County Medical Society met in the Medical Arts Auditorium, Fort Worth, June 18, with thirty-four members present. The paper named above was presented by George R. Enloe, followed by a discussion by W. C. Tatum, R. J. White, and Burgess Sealy.

A report was presented from the medical and hospital service committee, stating that Fort Worth needs a minimum of 350 additional hospital beds to meet the present demand.

John J. Andujar, seconded by S. J. R. Murchison, moved that the society notify the mayor of Fort Worth that it is opposed to making public the names of persons reported to the Health Department for various illnesses. The motion carried.

L. O. Godley, delegate to the State Medical Association House of Delegates, reviewed the proceedings of the meeting held in Galveston in May.

O. A. Hamilton, John C. Powell, Jr., and Robert C. Stokes were elected to membership upon application; Robert H. Rowland by transfer from Galveston County Medical Society.

It was voted upon motion by W. C. Tatum, seconded by Hub E. Isaacks, that the society dispense with its meetings during July and August.

Tom Green-Eight County Society

June 3, 1946

Tom Green-Eight County Medical Society, meeting in the Indian Room of the Cactus Hotel, San Angelo, on June 3, unanimously voted to approve any attempt to promote better hospital facilities for San Angelo. The society discussed the possibilities of San Angelo becoming a large medical center, pointing out that better medical facilities would result in a greater influx of people into the city from the surrounding territory, thus bringing added business and money into the community.

Leon F. Hutchins was named to replace Victor E. Schulze as a member of the advisory board of the San Angelo-Tom Green County Health Unit. Dr. Schulze, whose term on the board had expired, was commended for his efforts in behalf of the health unit and the medical society. K. B. Round was appointed to continue on the board in the place of Aubrey Lewis, who resigned some months ago.

Wichita County Society

June 11, 1946

(Reported by Robert L. Daily, Secretary)

Wichita County Medical Society held a stag party at the Wichita Falls Country Club on June 11, dining on steaks provided by Henry P. Ledford, president. Raymond A. Lemee, of Vernon, guest speaker related some of his experiences in the Philippines during the war.

The average attendance at monthly meetings of the Wichita County Society during the first six months of this year has been fifty-seven from a membership of about eighty-six.

The society reports that Wichita County has recently voted better than two to one to favor an $800,000 bond issue to build a new city-county hospital if and when federal assistance becomes available.

Seventh District Society

July 9, 1946

(Reported by M. I. Brown, Secretary)

Seventh District Medical Society met at the country home of G. F. Thornhill near Austin on June 9. Approximately 125 members and guests participated in a social hour and barbecue dinner preceding a business meeting presided over by the president, Robert Morrison, Austin. After a general discussion it was decided to reorganize the program of the society so that a full day, winter meeting of scientific interest and a summer meeting with a combined social and scientific program will be held.

Officers of the past term were reelected as follows: Dr. Morrison, president; J. D. Stephens, Bastrop, vice-president; and M. I. Brown, Austin, secretary.

BOOK NOTES

[1]**The Osseous System.** A Handbook of Roentgen Diagnosis. By Vincent W. Archer, M. D., Professor of Roentgenology, University of Virginia, Department of Medicine. Cloth, 320 pages. Price, $5.50. Chicago, The Year Book Publishers, Inc., 1945.

This is a handbook which admirably serves the purpose for which it was written. It is not intended as a comprehensive treatise on radiology. It is illustrated with numerous excellent reproductions of

[1]Reviewed by James R. Bost, M. D., Houston, Texas.

x-ray films, and will be of considerable value to the physician who owns his own x-ray equipment but has not had years of special training in radiology, and also to interns and residents. The descriptions are concise and clear, and the author particularly emphasizes conditions which are not pathological and often lead to misinterpretations.

[2]**Essentials of Clinical Proctology.** By Manuel G. Spiesman, B. S., M. D., Proctologist, Mt. Sinai and Edgewater Hospitals; Consulting Proctologist, Grant, Henrotin, and St. Elizabeth Hospitals; Former Head of the Cook County Hospital Rectal Clinic. Foreword by Anthony Bassler, M. D., F. A. C. P., LL. D., Consulting Gastroenterologist, St. Vincent's Hospital and other hospitals, New York City. Cloth, 238 pages. Price, $4.00. New York, Grune & Stratton, 1946.

This little book on proctology is divided into twenty-nine chapters. While from its brevity it could not be called encyclopedic, there is no excess verbiage. The illustrations are clear and easily understood; those on congenital malformations of the anus and rectum being especially so. The chapters are very well balanced as to length. Conditions of the colon are, for the most part, merely mentioned. Each paragraph has a capital letter heading, which makes it easy to find a topic quickly.

There is an especially good chapter on pectenosis, and one on anal fissure, accompanied by excellent illustrations. In the chapter on fissure, the author emphasizes the association of chronic fissure with infected crypts and pectenosis. The chapter on pruritis ani, while offering nothing new, is well written.

Possibly some proctologists will disagree with the chapter on hemorrhoids, in which the author still champions the clamp and cautery method of removal. Most proctologists at this time prefer a clean surgical procedure, in which such anal pathologic lesions as enlarged and infected anal crypts may be searched for and removed with little extra trouble.

While there are some other details with which some proctologists will not agree, such as the use of mineral oil as a laxative following anorectal operations, it is a carefully written book, and, on the whole, one well worth reading by anyone interested in anorectal disease.

[3]**New Goals for Old Age.** Edited by George Lawton. Cloth, 210 pages. Price, $3.00. New York: Morningside Heights, Columbia University Press, 1945.

"What everyone wants after all is a larger increment of maturity, a longer period in which to enjoy being physically, socially, and mentally effective; and additional opportunity for enjoying the privileges, the pleasures and the profound emotional experiences of adulthood." This quotation taken from the book epitomizes the content of "New Goals for Old Age," a volume of coordinated essays that make engaging reading for anyone interested in life—"The last of life, for which the first was made."

Every adult who is responsible for the care of an elderly parent should read the chapter, "The Older Person in the World of Today—In the Family." It is thought provoking to the point of consummating the ideal set forth not only for those elderly people for whom one may be responsible, but also in plans for one's own old age.

It is a book to be read and digested to the advantage of every business executive in America. It gives a clarifying insight into the problem of seniority versus younger personnel. After all, the world, and science and industry in particular, are entitled to greater benefits from the accrued experiences of the men and women who have been tried in the school of experience and they too are entitled to greater rewards for their accomplishments.

Various problems confronting our changing social order in relation to its increased content of persons over 65 years of age present a challenge which Dr. Lawton and his coadjutors have met squarely. They point out that "when people reach age 60 they should have a chance for a stock taking of their abilities and resources—intellectual, social, emotional, recreational." Occupational therapy, bibliotherapy, music therapy, mental, physical, and social capacities of elderly people are all adequately discussed. To any adult, this book should be both interesting and worthwhile reading, but particularly to the medical profession it is both entertainment and education.

[2]Reviewed by William C. Tatum, M. D., Fort Worth, Texas.
[3]Reviewed by Will S. Horn, M. D., Fort Worth, Texas.

DEATHS*

Dr. Arthur C. Horton, Brownsboro, Texas, died of leukemia June 5, 1946, at a Jacksonville hospital.

The son of Alfred Marion and Nancy (Mann) Horton, Dr. Horton was born August 27, 1873, at Aberdeen, Miss. He came to Texas, where he attended high school in Itasca, then went to St. Louis to attend old Barnes Medical College, from which he secured his medical degree in 1904. Dr. Horton returned to Texas to practice and was active in Henderson County, first at Leagueville, then at Murchison, and in more recent years at Brownsboro, until his death.

DR. ARTHUR C. HORTON

During his professional career Dr. Horton was a member of the State Medical Association and American Medical Association and was a charter member of the Henderson County Medical Society. He served the latter organization as president several terms and was vice-president at the time of his death. He was also a member of the Eleventh District Medical Society. He was city health officer and chairman of the Brownsboro Red Cross at the time of his death. He was a member of the Methodist Church and a Mason.

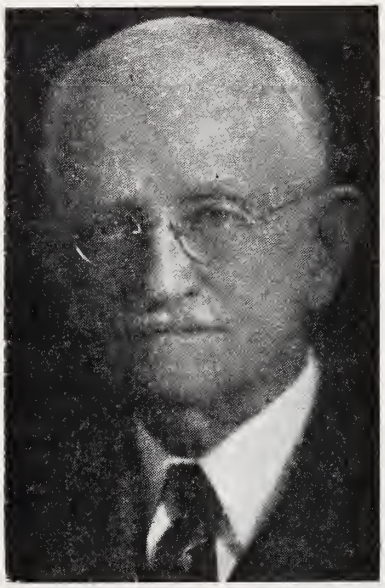
Surviving Dr. Horton are his wife, the former Miss Vinnie Scott, whom he married at Athens in September, 1906; two sons, Arthur Marion Horton, U. S. Navy, and Jack Horton, Brownsboro; ten daughters, Mrs. Nolan Killingsworth, Kilgore; Mrs. Bradley Hughes, Beaumont; Mrs. Jimmie Tindell, Brownsboro; Mrs. Joe Henry Cade and Mrs. Harry Tindell, Chandler; Miss Verna Joe Horton, Jacksonville; Miss Hazel Horton and Miss Peggy Horton, students at East Texas State Teachers College, Com-

*An obituary ordinarily will not be published more than four months after date of death. Coöperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

merce; Miss Patsy Ruth Horton, Orange; and Mrs. Albert Denton, California; a sister, Mrs. Lelia Porter, Murchison; and a brother, R. H. Horton, Athens.

Dr. Samuel Durfey Swope, El Paso, died June 13, 1946, of coronary occlusion.

The son of Morgan and Louvica Mariah (Flanders) Swope, Dr. Swope was born November 5, 1864, on a farm in Henderson County, Ky. He attended the schools there and taught for a short time before securing his medical degree from the University of Louisville in 1867. For the next eight years he practiced successively in Louisville, Henderson, and Marion, Ky. The health of his father and his brother made a move westward advisable at that time, and Dr. Swope located in Deming, N. M., where he was in practice from 1895 until 1923. In 1923 he moved to El Paso, practicing there until shortly before his death. Dr. Swope specialized in psychiatry.



DR. SAMUEL D. SWOPE

Dr. Swope throughout his professional career was active in medical organizations. He was a member of Kentucky State Medical Association and Southwestern Kentucky Medical Association, serving as president of the latter group in 1894. When he moved to New Mexico, then a territory, he joined the Territorial Medical Association and in 1897 became its president. From 1899 through 1905, with the exception of 1901, he was delegate to the American Medical Association, of which he was a member. He also served the American Medical Association lecture bureau. He was a member of Luna County Medical Association and of the New Mexico Medical Association after it was organized. He was a fraternal delegate from the New Mexico Association to the state associations of Colorado, Arizona, and Texas. He helped organize and was first president of the New Mexico Railway Surgeons Association, which later became the Southwestern Medical and Surgical Association. Upon moving to Texas, Dr. Swope affiliated with the El Paso County Medical Society and the State Medical Association, of which he was elected an honorary member at the 1946 annual session. He was also a member of the Southern Medical Association and the Southern Psychiatric Association, a fellow of the American College of Surgeons, and a diplomate of the American Board of Psychiatry and Neurology. He was a consultant in psychiatry for the El Paso City-County Hospital and was on the staffs of Hotel Dieu, Masonic Hospital, and Southwestern General Hospital.

While a resident of Deming, N. M., Dr. Swope served a term as mayor. He was also chairman of the Luna County, N. M., Democratic organization. He was a member, an elder and superintendent of the Sunday school of the First Presbyterian Church, El Paso.

In 1916 when Pershing led an expedition into Mexico against Pancho Villa, Dr. Swope volunteered as surgeon for the New Mexico National Guard. During World War I he served overseas as surgeon of the 143rd Machine Gun Battalion, and during World War II he was neurologist and psychiatrist on the medical examining board at the Fort Bliss reception center. At the time of his death, he held the rank of major in the Medical Corps Reserve, inactive.

Dr. Swope's hobbies included horseback riding, hunting, fishing, mechanics, gardening, archeology, and reading.

The former Miss Florence Eunice Crissey, whom Dr. Swope married in El Paso in June, 1936, survives. Also surviving Dr. Swope are three daughters, Mrs. Mary Lou Brady and Mrs. Charles P. Carroll, San Diego, Calif., and Mrs. Chester O. Grace, Carrolton, Mo., born to Dr. Swope's first wife, the former Miss Sudie Leslie Weaver, Henderson, Ky., whom he married in 1889 and who died in October, 1920. A second wife, the former Miss Margaret M. Maule, whom he married in New York City in December, 1921, died in El Paso in April, 1935.

On March 1, 1946, Dr. Swope completed fifty-nine years of medical practice. It has been estimated that during the first five years of his practice in Kentucky he rode on horseback a total of 27,000 miles.

In accordance with Dr. Swope's request, money which would have been spent for flowers to honor him is being donated through the El Paso County Medical Society to a fund to create a psychiatric suite in an El Paso hospital.

Dr. Henry H. Leeman, Windom, Texas, died June 3, 1946, at his home of coronary occlusion.

Dr. Leeman was born in February, 1868, at Honey Grove, but moved at an early age with his parents to Bonham. He attended the public schools and Carlton College there, going in early manhood to Dallas where he became a printer. He decided to study medicine, was graduated from the St. Louis College of Physicians and Surgeons in 1898, and later took postgraduate work at various centers. He returned to Texas to practice, locating at Windom, where he practiced continuously until his death. He had for a number of years also maintained an office at Bonham and was on the staff of the Allen Memorial Hospital there.

DR. HENRY H. LEEMAN

Throughout his professional career Dr. Leeman was a member of the State Medical Association and American Medical Association, through Fannin County Medical Society. In 1931 and again in 1937 he served the Fannin County Society as president. He was an elder in the Church of Christ and was a Mason.

Dr. Leeman is survived by his wife, Mrs. Annie

Leeman; two daughters, Mrs. Leah Dowlen and Mrs. Loneta Dowlen, Windom; a half sister, Mrs. T. J. Caldwell, Dallas; and three half brothers, Dr. E. W. Burnett, Rusk; Dr. Thomas R. Burnett, Mission; and J. E. Burnett, Dallas.

Dr. William Robert Kelly, Jasper, Texas, died March 13, 1946, after a year's illness.

Born in 1881 at Durant, Miss., Dr. Kelly attended the Memphis (Tenn.) Hospital Medical College and the medical department of the University of the South, Sewanee, Tenn., from which he was graduated in 1906. He practiced in Mississippi, Oklahoma, and Deweyville, Texas, before locating at Jasper in 1925. He was associated with the Richardson-Kelly hospital in Jasper until a few years ago, and was county health officer from 1937 until his death.

DR. WILLIAM ROBERT KELLY

Dr. Kelly was a member of the State Medical Association and the American Medical Association through the Jasper-Newton Counties Medical Society almost continuously from the time of his location in Texas. He was a member of the Methodist Church, a thirty-second degree Mason, and a Knight Templar.

Surviving Dr. Kelly are his wife, Mrs. Vassie Lee Kelly; two daughters, Mrs. Herselle Sawyer and Mrs. Opal Shaw, Jasper; two sons, Louis Kelly, Newton, and W. R. Kelly, Jr., Crockett; two step-daughters, Mrs. Mynell McGinty, Jasper, and Mrs. Bonnie Bell, Philadelphia, Pa.; three step-sons, Varrell Crowder, Jacksonville, Fla., Hoyle P. Crowder, with the Army stationed at Daytona Beach, Fla., and Jesse H. Cannon, Bogata; one sister, Mrs. W. W. Purdom, Calvert; one brother, Madison Kelly, Calvert; and two grandchildren, Sherry Beth and John Carlton Sawyer, Jr., Jasper.

Dr. Menard William Lowrey, Gatesville, Texas, died of lymphatic leukemia May 24, 1946.

Born February 8, 1875, in Peoria, Hill County, Texas, Dr. Lowrey was the son of Dr. William J. and Elizabeth Lowrey. He attended high school at Lindale and went to Weatherford Junior College before securing his medical degree from old American Medical College in St. Louis in 1897. He began practice with his father at Hester, Texas, upon his graduation, moved to Richardson in 1900, to Sanger in 1904, and to Gatesville in 1909. He remained active in Gatesville until shortly before his death.

Dr. Lowrey was a member throughout his professional career of the State Medical Association and American Medical Association, for a short while through Denton County Medical Society and then through Coryell County Medical Society. He was secretary of the Coryell County Society from 1930 through 1933 and again in 1943, and was president of the society in 1934, 1935, 1945, and 1946. He was also a member of Twelfth District Medical Society.

In 1918 Dr. Lowrey was elected a city councilman, serving in that capacity until 1928 when he was elected mayor of Gatesville. He continued as mayor until 1936, and during his administration the municipal building was erected and improvements were made in the city park, school plant, athletic field, and sewerage and water systems.

February 8, 1911, Dr. Lowrey married Miss Katherine Leo Halbrook, who survives. Also surviving are two sons, both doctors, E. E. Lowrey, Gatesville, and Capt. O. W. Lowrey, Army Medical Corps; one daughter, Mrs. W. J. Holt, Gatesville; two brothers, Robert Lowrey, Redwood City, Calif., and Lester Lowrey, Fullerton, Calif.; and two sisters, both of California.

Dr. Clark Anson Wilcox, Wichita Falls, Texas, died April 4, 1946, of aplastic anemia.

Dr. Wilcox, the son of Charles E. and Carrie (Horner) Wilcox, was born at Scottsville, N. Y., February 7, 1890. He received a bachelor of science degree in civil engineering from the University of Michigan, Ann Arbor, prior to obtaining his medical degree from the New York Homeopathic Medical College and Flower Hospital, New York City, in 1916. He then served an internship at the Lying-In and Flower Hospitals in New York City. In 1917, he was commissioned a first lieutenant in the Medical Reserve Corps of the Army. After several years in the Reserve, he accepted the commission of captain in the Medical Corps of the U. S. Army, later resigning to do civilian practice in Wichita Falls. He was made a major in the Reserve Corps in 1924 and was promoted to lieutenant colonel in 1931. From 1923 until his death Dr. Wilcox was radiologist with the Wichita Falls Clinic and Clinic-Hospital.

DR. CLARK ANSON WILCOX

Dr. Wilcox was a member of the State Medical Association and the American Medical Association through Wichita County Medical Society. He was also a member of the Texas Radiological Society and served both that organization and Wichita County Medical Society as president. He was a member of the Radiological Society of North America, a fellow of the American College of Radiology, a fellow of the American College of Physicians, and a diplomate of the American Board of Radiology. He was a member of the Baptist Church, Phi Alpha Gamma medical fraternity, Scottish Rite, Shrine, Knights Templar, and Blue Lodge.

April 28, 1923, in Kansas City, Mo., Dr. Wilcox married Miss Ruth Gracelon, who survives. Also surviving are two daughters, Miss Allene Wilcox and Mrs. J. R. (Susan Wilcox) Kolb, Jr., both of Wichita Falls; one sister, Mrs. Ruth W. Engle, Compton, Calif.; and one grandson, James Clark Kolb, Wichita Falls, born April 2, 1946.

Texas State Journal of Medicine

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Vol. XLII **September, 1946** **No. 5**

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION AND PUBLIC HEALTH IN TEXAS

The Official Family for 1946-1947.—As per an annual custom of many years standing, there is published herewith, early in the administration year, the names of all officers and members of boards, councils, and committees upon whom will fall the responsibility of the affairs of the Association during the current year. The purpose of publishing these names is threefold: first, as a matter of record; second, to honor them for the tasks they will assume; third, and of the greatest importance, to facilitate the work of the Association.

And to aid the last named purpose an effort will be made to discuss briefly the duties and functions of the different groups for the benefit of any of our readers not familiar with the machinery of the Association and how it works.

First, the President is the official who brings leadership to all Association affairs. On him and the Secretary, more than any other, falls the responsibility of seeing to it that the Association maintains a steady dynamic progress in all of its manifold purposes. The President-Elect and Vice-Presidents, are understudies in these endeavors, while the Treasurer is all that the name implies, custodian of the financial assets of the Association.

The Board of Trustees constitute the board of directors of our organization. They manage completely its financial affairs, with the Secretary as the executive officer for the Board. Not only the spending of money and the management of investments for the Association and all of its properties, including the Library, but the employment and salaries of the personnel in the central office, are their duties. Also, they are the board of publication for the JOURNAL and with the Editor, who is employed by the Board, have full responsibility for the management of the official publication of the Association, the TEXAS STATE JOURNAL OF MEDICINE.

The Board of Councilors carry heavy responsibilities for the Association. The Association looks to them as leaders in their respective districts in all its affairs. The activities of individual members, and of county medical societies, both scientific and organizational, are their responsibilities. All matters pertaining to ethics and professional conduct are within their sphere. Each councilor has a vice-councilor who is both an understudy and aid in the discharge of councilor duties, and a substitute in case of incapacity of the councilor to act.

Our delegates to the American Medical Association are freighted with the responsibility of properly representing our Association in the national body, and are our liaison with the parent body in its activities and our own.

The major year around activities of the Association are wisely centered in councils and committees with overlapping terms of office.

Our Council on Medical Defense sees to it that our members are protected, under definite regulations from unjustified malpractice suits.

The Council on Scientific Work, together with the officers of the eight scientific sections, who, with the President and Secretary are ex-officio members, have complete charge of and make all arrangements for the scientific programs, scientific exhibits, and myriad details connected with our annual sessions in coöperation with other special committees and important local committees.

Our Council on Medical Economics is charged with unusually heavy responsibilities in determining for the Association the facilities for medical services in the state, existing deficiencies, and plans and programs to make better medical services available to all classes of people at fees they can afford to pay and under conditions which are fair and equitable to the medical profession.

Our Committee on Legislation has the considerable responsibility of causing to be enacted legislation which is in the public interest as far as medicine and the public health are concerned, and of opposing such legislation as may be hurtful to the public. This year in particular will be one of unusual significance in that connection. The Association proposes to sponsor legislation which will eliminate, as far as legislation can, the charlatan and the quack in Texas.

The functions of such groups as the Committees on Collection and Preservation of Records, Health Problems in Education, Cancer, and Postgraduate Medical Education, are all implied in their titles. President Cody is especially desirous of seeing studies and recommendations made that will materially improve postgraduate opportunities in medicine in Texas.

The Committee on Tuberculosis was given a higher status as a standing committee with overlapping terms of office by amendment to the By-Laws at the last annual meeting of the House of Delegates, with the thought that this disease in Texas warrants special study.

Special committees whose members are appointed for one year only do much of the Association's work. The titles of these committees are indicative of their functions. Each member of each of these committees has been carefully selected by the President because of his particular qualifications for the task at hand.

Among these might be mentioned the Committee on Medical Education and Hospitals, whose functions may well assume extraordinary proportions as a result of the enactment of the Hill-Burton bill into law by the last Congress.

In accordance with recommendations of the last House of Delegates, a special Committee on Revision of the Constitution and By-Laws was set up, composed of the President, President-Elect, Board of Trustees, and Secretary, who will make a careful revision of the Constitution and By-Laws for the consideration of the next House of Delegates.

The Public Relations Committee will continue to be charged with a great responsibility in seeing that the affairs of medicine, and of the State Medical Association in particular, are presented in a proper light and in an understandable way to the public and, as for that, to members of the medical profession itself.

President Cody continued the old Procurement and Assignment Committee of wartime into the present turbulent peace, giving it a both new and old title, Military Affairs.

It is not possible to do more here than highlight some of the functions of the many committees of the Association. Any member who has anything in mind that he feels would improve the organization should communicate either directly with the chairman of the proper committee, or, if in doubt as to which committee, to the Secretary of the Association. He may rest assured that any suggestion will receive serious and appreciative consideration.

The official family for 1946-1947 follows:

OFFICERS

C. C. Cody, President, Houston.
B. E. Pickett, Sr., President-Elect, Carrizo Springs.
S. D. Whitten, Vice-President, Greenville.
C. P. Yeager, Vice-President, Corpus Christi.
J. M. Campbell, Vice-President, Goldthwaite.
Holman Taylor, Secretary, Fort Worth (one year).
K. H. Beall, Treasurer, Fort Worth (one year).

BOARD OF TRUSTEES

T. C. Terrell, Chairman, Fort Worth (five years).
E. A. Rowley,[1] Secretary, Amarillo (three years).
J. B. McKnight, Sanatorium (four years).
W. B. Russ, San Antonio (three years).
E. W. Bertner, Houston (one year).

BOARD OF COUNCILORS

First District, Ralph H. Homan, El Paso (three years). Leigh E. Wilcox, El Paso, Vice-Councilor.

Second District, A. H. Fortner, Sweetwater (two years). C. A. Rosebrough, Sweetwater, Vice-Councilor.

Third District, Harvey H. Latson,[2] Amarillo (one year). G. T. Vinyard, Amarillo, Vice-Councilor.

Fourth District, O. N. Mayo, Brownwood, (three years). R. E. Windham, San Angelo, Vice-Councilor.

Fifth District, C. E. Scull, Chairman, San Antonio (one year). W. H. Hargis, San Antonio, Vice-Councilor.

Sixth District, W. E. Whigham,[3] McAllen (one year). J. E. Pilcher, Corpus Christi, Vice-Councilor.

Seventh District, R. T. Wilson, Secretary, Austin

1. Appointed August 1, 1946, to fill the vacancy created by the resignation August 1, 1946, of Dr. S. E. Thompson, Kerrville.
2. Appointed August 1, 1946, to fill the vacancy created by the appointment August 1, 1946, of Dr. E. A. Rowley to the Board of Trustees.
3. Appointed to fill the vacancy created by the death of Dr. J. G. Webb, Mercedes, April 17, 1946.

(two years). J. R. de Steiguer, San Marcos, Vice-Councilor.

Eighth District, F. J. L. Blasingame, Wharton (two years). Harry H. Brown, Jr., Yoakum, Vice-Councilor.

Ninth District, Ghent Graves,[1] Houston (two years). Hatch W. Cummings, Houston, Vice-Councilor.

Tenth District, A. E. Sweatland, Lufkin (two years). William H. Warren, Center, Vice-Councilor.

Eleventh District, J. M. Travis, Jacksonville (three years). C. E. Willingham, Tyler, Vice-Councilor.

Twelfth District, G. V. Brindley, Temple (one year), J. W. David, Corsicana, Vice-Councilor.

Thirteenth District, R. G. Baker, Fort Worth (three years). H. H. Cartwright, Breckenridge, Vice-Councilor.

Fourteenth District, C. C. Nash, Dallas (three years). H. Leslie Moore, Dallas, Vice-Councilor.

Fifteenth District, C. A. Smith, Texarkana (one year). Joe Nichols, Atlanta, Vice-Councilor.

Delegates to A. M. A.

Holman Taylor, Fort Worth (two years).
F. J. L. Blasingame, Wharton (two years).
H. R. Dudgeon, Waco (one year).
B. E. Pickett, Carrizo Springs (one year).
E. H. Cary, Dallas (one year).

Alternates

R. B. Anderson, Fort Worth (two years).
L. H. Reeves, Fort Worth (two years).
E. W. Bertner, Houston (one year).
H. Leslie Moore, Dallas (one year).
A. C. Scott, Temple (one year).

Council on Medical Defense

W. D. Jones, Chairman, Dallas (two years).
Holman Taylor, Secretary (ex-officio), Fort Worth.
L. B. Jackson, San Antonio (four years).
A. P. Howard, Houston (three years).
W. L. Baugh, Lubbock (one year).

Executive Council

Ex-officio, the President (Chairman), and the Secretary (Secretary of the Association), President-Elect, Vice-Presidents, Board of Trustees, Board of Councilors, and the Legislative Committee.

Council on Scientific Work

Ex-officio, the President and Secretary of the Association and Officers of Scientific Sections.
A. C. Scott, Chairman, Temple (two years).
Joseph B. Copeland, San Antonio (five years).
R. B. Alexander, Waco (four years).
J. S. McCelvey, Temple (three years).
Tom G. Glass, Marlin (one year).

Council on Medical Economics

H. E. Griffin, Chairman, Graham (three years).
Tom B. Bond, Fort Worth (five years).
H. R. Dudgeon, Waco (four years).
W. R. McWilliams, Del Rio (two years).
W. F. Starley, Galveston (one year).

Committee on Legislation

J. H. Burleson, Chairman, San Antonio (two years).
C. C. Cody, Jr. (ex-officio), Houston.
Holman Taylor, Secretary (ex-officio), Fort Worth.
L. H. Reeves, Fort Worth (five years).
J. Allen Kyle, Houston (four years).
Z. T. Scott,[2] Austin (three years).
N. D. Buie, Marlin (one year).

1. Appointed May 17, 1946, to fill the vacancy created by the resignation of Dr. J. E. Clarke, Houston.
2. Appointed June 24, 1946, to fill the vacancy created by the resignation of Dr. Joe Gilbert, Austin.

Committee on Collection and Preservation of Records

W. B. Russ, Chairman, San Antonio (one year).
E. W. Bertner, Houston (five years).
A. A. Ross,[1] Lockhart (four years).
Marvin L. Graves, Houston (three years).
John T. Moore, Houston (two years).

Committee on Health Problems in Education

O. M. Marchman, Chairman, Dallas (two years).
Sam N. Key, Austin (five years).
W. S. Barcus, Fort Worth (four years).
C. P. Yeager, Corpus Christi (three years).
Allen C. Hutcheson, Houston (one year).

Committee on Cancer

E. W. Bertner, Chairman, Houston (two years).
David A. Todd, San Antonio (five years).
George T. Caldwell, Dallas (four years).
Frank C. Beall, Fort Worth (three years).
A. A. Ross, Jr., Lockhart (one year).

Council on Postgraduate Medical Education

David W. Carter, Jr., Chairman, Dallas (five years).
Dick P. Wall, Galveston (four years).
A. O. Singleton, Galveston (three years).
Lee Rice, San Antonio (two years).
DeWitt Neighbors, Fort Worth (one year).

Committee on Tuberculosis

C. M. Hendricks, Chairman, El Paso (five years).
Charles J. Koerth, Junction (four years).
David McCullough, Kerrville (three years).
Howard T. Barkley, Houston (two years).
Jesse B. White, Amarillo (one year).

General Arrangements Committee for Annual Session. (All of Dallas).—Frank A. Selecman, Chairman; Edwin L. Rippy, Howard K. Crutcher, John L. Goforth, C. D. Bussey.

Committee on Transportation.—W. E. Vandevere, Chairman, El Paso; Albert T. Cook, Laredo; John R. Martin, Georgetown; J. D. Nichols, Atlanta; Leroy Trice, Palestine.

Committee on Memorial Exercises.—M. D. Levy, Chairman, Houston; Sam E. Thompson, Kerrville; J. J. Crume, Amarillo; Elbert Dunlap, Dallas; J. H. Caton, Eastland.

Committee on Scientific Exhibits.—X. R. Hyde, Chairman, Fort Worth; H. L. Hilgartner, Austin; Arthur Grollman, Dallas; Stuart A. Wallace, Houston; Robert M. Moore, Galveston.

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1. Appointed August 6, 1946, to fill the vacancy created by the death of Dr. H. W. Cummings, Hearne, July 29, 1946.

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The Status of National Health and Medical Legislation at the end of the Seventy-Ninth Congress is difficult to evaluate despite reports from many authoritative sources in Washington, including, first, the Washington office of the Council on Medical Service of the American Medical Association headed by Dr. Joseph S. Lawrence. Dr. Lawrence has done a magnificent job in attempting to keep the medical profession of the United States informed and alerted on all legislation in which it should be interested.

Brief reference will be made here only to the bills in which American medicine was most vitally interested in the Congressional session just concluded.

S. 1050, introduced early in the Seventy-Ninth Congress by Senators Wagner and Murray in the Senate, and H. R. 3293, by Representative Dingell in the House, and its successor, S. 1606 and H. R. 4730, by the same authors, introduced immediately following the announcement of President Truman's cataclysmic national health program, now lie dormant in the committees in which they have long reposed, after extended hearings on the Wagner-Murray-Dingell bill of 1946, which were as ridiculously one-sided in the matter of witnesses allowed to appear as the author-chairman, Senator Murray, could possibly have arranged. In spite of his efforts, however, enough intelligent opposition was heard, and authoritative factual testimony developed through the brilliant interrogations of Senator Donnell, that Senator Murray's committee did not act on the bill before adjournment. It is possible that hearings may be resumed in the fall, and while improbable, President Truman could call a special lame duck session after the November elections, before the new Congress meets in January, 1947, in an effort to rush through some of his favored so-called social security program.

S. 1318, the Maternity and Child Welfare Act, by Senator Pepper, which, if enacted, would have perpetuated the E. M. I. C. war program into peace times, extended its provisions to all classes of the American public, regardless of financial circumstances, and made infants of all persons below 21 years of age, also passed into at least temporary oblivion with the adjournment of the Seventy-Ninth Congress, following what has been referred to as a "quickie" and also one-sided hearing. Only three witnesses were permitted to appear in opposition, a distinguished pediatrician and a distinguished obstetrician representing the American Medical Association, and a representative of the American Dental Association. Others who had pleaded for an opportunity to be heard in opposition were allowed only to submit their statements in writing for the records of the committee. When Senator Pepper realized that a favorable report might not be had from the committee, strategy was quickly changed and S. J. R. 177 was offered by the committee as a substitute for S. 1318. The purport of the resolution was to increase the appropriation for the Children's Bureau about threefold for the next year without extending its functions or activities. The increases provided were (1) from $5,000,000 to $15,000,000 for the promotion of health of mothers and children; (2) from $3,870,000 to $10,000,000 for the care of crippled children; (3) from $1,510,000 to $5,000,000 for

child welfare services; and (4) $1,500,000 for administrative purposes.

The Senate Finance Committee, to which S. J. R. 177 was referred, did not act upon it. However, when H. R. 7037, Social Security Act Amendments of 1946, was before the Senate, it was amended by adding provisions for increasing the appropriation to the Children's Bureau for maternal and child welfare, crippled children, and dependent children activities in accordance with the provisions of S. J. R. 177. In conference the House committee insisted upon a reduction of the total amount to $14,525,000. This reduction was accepted by both houses and H. R. 7037 has been signed by the President. While the appropriation was increased there was no change in the law. As cryptically stated by one analyst, "the Children's Bureau has more money but no more power."

Again it is possible in the event of a lame duck session, or even without such session, for a revival of the Pepper bill in the form of additional hearings, and it is difficult to believe that, regardless of these eventualities, Senator Pepper will fail to introduce into the new Congress legislation very similar to that embodied in S. 1318 of the Seventy-Ninth session.

Whatever happens in regard to the two bills discussed, or similar legislation, the State Medical Association of Texas will again insist upon being heard, and witnesses have already been appointed to represent the Association at Washington if necessary.

S. 1850, the bill providing for a National Research Foundation, in which the medical profession was naturally interested, died in committee.

The only two bills originating in the Seventy-Ninth Congress, enacted into law that were of special interest to the medical profession were S. 191, the Hill-Burton bill, Hospital Construction Act, now Public Law 725, and H. R. 4512, providing for a National Neuropsychiatric Institute, now Public Law 487. The former bill, which received the support of the American Medical Association and the State Medical Association of Texas, is discussed elsewhere in these columns (p. 305). The bill providing for a National Neuropsychiatric Institute became a law with little if any consideration by the official groups of medicine, perhaps because their hands were so full in other directions with legislation of far more serious import as far as the public health is concerned.

Again it may be said that while American medicine is being given a breathing spell with the adjournment of the Seventy-Ninth Congress, even though there may be no lame duck session or further hearings on the Wagner-Murray-Dingell bill in 1946, we may be certain that those who want to change the way of American life to a more socialistic pattern are even now planning their strategy for the 1947 Congress. From all reports received, Texas will again be represented in Congress in 1947 by a delegation opposed to such changes in general and to changes in the practice of medicine in particular. That, at least, is reassuring.

The Hill-Burton Bill (S. 191), commonly known as the Hospital Construction Bill, passed by the Seventy-Ninth Congress, became Public Law 725 on August 13, 1946, on which date it was signed by President Truman. This measure was approved by the American Medical Association and the State Medical Association of Texas. The provisions of the bill were discussed in the November, 1945, JOURNAL. They were referred to again in the December, 1945, issue, in connection with an editorial announcement of the Advisory Council to the State Board of Health, the official agency in Texas now conducting a survey of the state to determine what hospital construction is needed, where it is needed, and whether communities can support such facilities if and when they are constructed. The same agency will also determine where public health units are needed and where they can be expected to be properly supported locally. This survey was discussed fully again in these columns in the March, 1946, JOURNAL (page 559).

Dr. Victor Johnson, secretary of the Council on Medical Education and Hospitals of the American Medical Association, who represented American medicine in hearings on the bill in Congress, voiced the following caution regarding the measure, in an address recently to the graduates of the University of Oklahoma School of Medicine, prior to its enactment into law:

> "Because the program is experimental in nature, because the needs can be determined only by scientific surveys, the funds allotted should be reasonably restricted to prevent a vast program of construction of hospitals which are not needed or cannot be maintained. A major effort in this program must be exerted in the direction of inhibition. Already we have encountered an avalanche of local demands for new hospitals, dictated as often by local pride as by real need. There is a tendency for every community to think it should have its own small hospital, with complete disregard for the fact that three nearby communities would be better served by one hospital of 150 beds than by three separate hospitals of fifty beds, as is also true of schools, for example."

The U. S. Public Health Service announced recently the creation of a Division of Hospital Facilities to assist Surgeon General Thomas Parran in carrying out the provisions of the Hospital Survey and Construc-

tion Act. According to a release dated August 20, 1946, "This will include assistance to the States, their political subdivisions, and non-profit organizations in matters relating to the study, construction and operation of hospitals. The Division will also assist the Surgeon General in preparing regulations, determining allotments and grants and considering applications, plans and projects."

Dr. George W. Cox, State Health Officer, to whom responsibility for the survey in Texas has been delegated by the State Board of Health, received a communication on this subject under date of August 27, 1946, from the Senior Surgeon of the U. S. Public Health Service in charge of the district office for Texas. It is published here in full because of the information it contains, and because of the great interest of the medical profession in the program. The letter follows:

"This office is in receipt of further comments on the passage of the Hospital Survey and Construction Act. On August 13, 1946, President Truman signed this measure, known prior to enactment as S. 191, the Hill-Burton Bill, now Public Law 725, 79th Congress. As soon as printed copies are available, copies will be forwarded to you, as well as copies of House Report Number 2519 of July 13, 1946.

"The Surgeon General is sending letters to all the Governors on this matter. This correspondence has been directed to the Governors, inasmuch as the Hospital Survey and Construction Act, with respect to both the survey and planning and the construction phases of the program, leaves up to the State the designation of the State Agency to carry the administrative responsibility. On the basis of $3,000,000.00 appropriation for survey and planning and $75,000,000.00 for construction (over a 5 year period), the allotment for Texas is listed for survey and planning, $145,051.00, and construction $4,842,-075.00, which automatically becomes available upon the Surgeon General's approval of the State application under Part B of the Act. The Governor has been or will be notified of the amounts of the allotments. The actual amount available, of course, will be dependent upon the actual appropriation made by Congress.

"Standard application forms on which the State of Texas may request Federal funds for survey and planning are now being processed. These are to be released through the District Office. It appears to be the policy of the Division of Hospital Facilities to permit consideration of State requests for Federal funds for survey and planning only when made on these Federal forms and consideration in Washington only when accompanied by the District Office recommendation. This office is informed that when these forms and instructions are ready they will be made available through this office to forward to you. It is also our understanding that the Governor will be notified of their availability.

"An attempt will be made by this office to follow a uniform policy to discourage premature direct inquiries from communities desiring construction funds. This policy is substantiated by the requirements of the law which state that before the Surgeon General can consider any request for Federal funds, for a construction project, there must be a State plan approved by the Surgeon General; that the State Agency, following the Surgeon General's approval of the State plan, must have recommended the construction application for approval; and that there must have been made the submittals and assurances of the availability from non-Federal sources of two-thirds of construction costs and all costs of hospital maintenance and operation. The Surgeon General has requested the coöperation of the Governors in highlighting these points in any State publicity given the program.

"The first deficiency bill of 1947, which has been approved by the President, contains an appropriation of $2,350,000 to carry out the provisions of Title 6 of the Public Health Service Act as amended, for assistance to the States and for administrative expenses of the Public Health Service in connection with the program. It is anticipated that $1,500,000 will be allocated immediately to the States for conducting surveys and developing plans, as required by the Act. No funds for construction purposes were appropriated by the last Congress.

"This office will endeavor to keep you advised of developments by correspondence."

As has been stated in previous editorial discussions of this subject and program, the State Medical Association has been vitally interested in the matter from the beginning. Fortunately the Association is repesented on the Advisory Council to the State Board of Health, in connection with the survey and construction program, in the persons of the President, Secretary, Chairman of the Board of Trustees, Chairman of the Board of Councilors, Chairman of the Legislative Committee, Chairman of the Council on Medical Economics, and Chairman of the Public Relations Committee. At least these were the officials appointed during the past year by Governor Stevenson on the request of our Legislative Committee, and it is anticipated that changes will be made on the Council as changes take place in the above offices, provided the Governor is agreeable to making the new appointments.

In addition to this representation the State Medical Association is now busily conducting a survey on its own of hospital and medical service facilities in Texas, accumulating its material from the 124 county medical societies in Texas. The Council on Medical Economics and the Committee on Medical Education and Hospitals will study and evaluate these data, which will be of very great value to official representatives of the Association on the Advisory Council to the Board of Health when the survey of that body is completed and the time comes for recommendations as to where hospital and public health facility construction is needed and where it can and will be supported locally.

American medicine is faced with one of its greatest challenges for leadership in matters pertaining to public health as a result of the passage of the Hill-Burton bill. It will accept and meet that challenge as faithfully as it has discharged every public obligation pertaining to medical affairs in its long and

glorious history that has given to the American people the finest medical care of any people in the world today. Facts and figures fully support that statement.

Finally, it is recommended that requests for information regarding this matter be addressed to Dr. George W. Cox, State Health Department, Austin 2, Texas. It is not likely that the survey will be finished for several months, and no state plan or recommendations concerning hospital construction can be made until it is finished. Actual construction can be authorized then only after the plan has been approved by the Surgeon General of the U. S. Public Health Service. Dr. Cox will, however, have the latest available information on the subject.

New Films for the Motion Picture Library.—Announcement is made here of the recent acquisition of five motion picture films on medical subjects which are now available for lending to county medical societies, physicians, and other interested persons. Two of the five recently acquired films are on subjects for professional audiences only, and three are for lay audiences. The Motion Picture Film Library now contains thirty-three films suitable for lay audiences and forty-six appropriate for professional (medical) audiences only. Program chairmen of county medical societies who do not have lists of the films available in the Library, with descriptions of each, should by all means request them. All of the films are 16 mm. Some are silent and some are sound; some in black and white and some in color. They cover a wide range of subjects.

The three films for lay audiences, acquisition of which is announced here, were made available to the Library on a long term loan basis by the Texas Tuberculosis Association, Austin, and Standard Brands, Inc., Dallas. Grateful appreciation to these organizations is expressed for their fine contributions to the Library for the use of physicians and others interested in health education.

Descriptions of the five films referred to follow:

Aids in Muscle Training. 16 mm., silent, showing time, 12 minutes. This film was prepared by the Council on Physical Therapy of the American Medical Association, Chicago. It gives a demonstration of sling suspension exercises for the upper and lower extremities, and three kinds of "walkers" for reëducation exercises. It is suitable for professional audiences.

Golden Glory. 16 mm., sound, showing time, 31 minutes. (Available through the courtesy of Standard Brands, Inc., Dallas.) This film is keyed to the interests of the National Nutrition Program, and contains no commercialism or advertising. It is produced for showing to general assembly groups in colleges, high schools, and elementary schools, or to any lay group interested in good health. It stresses the importance of eating, as far as possible, something from each of the Basic Food Groups each day. In bringing out its lesson, it tells the story of Mark Carleton, who was mainly responsible for America's abundance of one of our most vital foods —wheat. It points out that pioneers and scientists have made fine foods available to us, and that the science of nutrition can tell us how to use them. But it is solely up to each person to keep himself fit by eating properly of the right foods.

Modest Miracle. 16 mm., sound, showing time, 20 minutes. (Available through the courtesy of Standard Brands, Inc., Dallas.) This film is suitable for lay audiences, and it tells the story behind the discovery of Vitamin B_1 and its importance to health.

TB, This Is. 16 mm., sound, showing time, 10 minutes. (Available through the courtesy of the Texas Tuberculosis Association, Austin.) This film outlines the cause, spread, cure, and prevention of tuberculosis, with the clarity and pace of an up-to-the-minute factual newsreel. It is a forthright presentation of the problem and what remains to be done about it, and is designed to meet the demand for a brief teaching film to give the layman correct information on tuberculosis, but in easily understood and arresting form.

Underwater Therapy. 16 mm., silent, showing time, 16 minutes. This film was prepared by the Council on Physical Therapy of the American Medical Association, Chicago, and is a presentation of therapeutic use of large and small exercise pools, Hubbard tanks, and home-made tanks, and demonstration of types of exercises given in cases such as infantile paralysis, cerebral palsy, and postoperative congenital dislocation of the hip. It is suitable for professional audiences.

University of Texas Postgraduate Program.—The 1946-1947 schedule of postgraduate courses at the University of Texas Medical Branch has been announced by Dr. George M. Decherd, Jr., director of the Postgraduate Division. Members of the University staff and outstanding speakers from throughout the nation will teach.

Two new types of courses have been included in the plans for the coming year. A week-long review of the fundamental medical sciences in preclinical fields with particular reference to their application to clinical medicine will begin next February, and tumor conferences will be held on one Saturday every three months. The tumor conferences will cover various types of neoplastic diseases, utilizing available clinical material, but half of each conference will be devoted to an intensive study of a particular group of tumors, such as lung or breast tumors, under the direction of an authority in that specific field.

The first of the special courses, the Fourth Postgraduate Conference in Pediatrics, to be held the week of October 28 to November 2, will be offered in cooperation with the University of Texas Child Health Program and the Division of Maternal and Child Health of the State Health Department. An allowance for the $25 tuition, travel, and a daily stipend has been made available by the State Health Department for Texas physi-

cians who are accepted for the course, preference being given in the following order: (1) physicians recently discharged from military service, (2) general practitioners interested in pediatrics, (3) physicians associated with health units, and (4) pediatricians and other specialists interested in the childhood age period. About eighty physicians can be accommodated.

The pediatrics conference will deal with the problem of diarrhea in infants, endocrine disorders in children, infant feeding, the premature infant, neurological problems in childhood, virus diseases, acute contagious diseases of childhood, convalescent care, abdominal pain in children, pyloric stenosis and pyloric spasm, and splenomegaly as a diagnostic problem. Six outstanding physicians will be guest speakers.

Applications to attend the pediatrics conference may be obtained from Dr. Arild E. Hansen, Chairman, Department of Pediatrics, University of Texas School of Medicine, Galveston.

In addition to the refresher courses outlined below, residencies in various specialties, preclinical work preparatory to board examinations, externships, and specially arranged studies are being offered by the University. Dr. Decherd again extends a welcome to visitors to the various classes, clinics, conferences, and seminars, and offers the cooperation of his staff in supplying speakers for medical meetings upon request.

The tentative schedule of refresher courses for 1946-1947 follows:

Pediatrics, October 28-November 2.
Surgery, November 18-23.
Tumor Conference, December 14.
Internal Medicine, February 3-8.
Fundamental Medical Sciences, February 24-March 1.
Tumor Conference, March 8.
Obstetrics, March 10-15.
Physical Medicine, March 3-7.
Pediatrics, March 31-April 5.
Tumor Conference, June 14.
Tumor Conference, September 13.

Dr. S. E. Thompson Resigned from membership on the Board of Trustees on August 1, 1946, and was succeeded in office on that date by Dr. E. A. Rowley, of Amarillo, Councilor of the Third District of the Association, on the appointment of President Dr. C. C. Cody.

Dr. Thompson was elected a Trustee of the Association by the House of Delegates in 1939, filling a vacancy on the Board caused by the death of Dr. John W. Burns, of Cuero. In 1940, Dr. Thompson became Chairman of the Board, continuing in that office until his resignation was regretfully accepted by the President.

No effort will be made here to pay tribute to the outstanding services rendered by Dr. Thompson during his illustrious official career with the State Medical Association, which he also served as President in 1934-1935. But it would be ill fitting, indeed, not to call attention to the retirement of an officer of the Association whose leadership has no peer in its history and which was exercised during a most turbulent and difficult period. Dr. Thompson's greatest value as a leader lay in his ability to keep the respect of opposing elements on all controversial matters. Both sides invariably sought his advice and accepted it. Because of this he was able to compose differences and direct action always to the good of the Association.

Dr. Thompson's leadership fortunately will not be lost in his official retirement. His counsel will continue to be sought by those who are in authority in the Association as long as Dr. Thompson is available for such consultation, which, it is hoped, will be for many years.

Dr. E. A. Rowley, who succeeds Dr. Thompson on the Board, has rendered exceptionally fine service to the Association as Councilor of the Third District since 1939. He is particularly well known for his services as a member of the Committee on Medical Licensure and as one of the leaders in the movement for basic science legislation in Texas, in which matter the Association is greatly interested at the present time. Dr. Rowley is sound, sane, and practical. President Cody is to be commended for his appointment.

Dr. H. H. Latson, of Amarillo, who was appointed by President Dr. Cody to succeed Dr. Rowley as Councilor of the Third District, comes to the Board of Councilors highly recommended by all who know him as an interested, well informed, and dynamic leader.

CURRENT EDITORIAL COMMENT*

Migraine and its Association to Allergy.—Migraine is a term which has been used to designate paroxysmal severe headaches which are frequently preceded by visual disturbances and associated with nausea and vomiting. Recently there has been too great a tendency to associate this type of headache with some form of allergy without adequate medical study and observation.

In reality this type of headache constitutes a symptom which should entail more general consideration of the patient as a medical problem.

Wolff, Ray, and others have made inter-

*This department of the JOURNAL presents editorial comments on current items pertaining to the science, art and practice of medicine, contributed by members of the State Medical Association and scientists closely associated with the medical profession of Texas. Invitation is hereby extended to any member of the State Medical Association of Texas to submit such discussions for this department. The discussions should not be more than 500 words in length.

esting studies and contributions concerning the mechanism of pain and migraine. They have demonstrated increased amplitude of oscillation of arteries during an attack of migraine and have shown a subsequent decreased amplitude of oscillation following the administration of ergotamine. From this it would appear that the location and severity of the pain would depend on the vessels involved and the degree of oscillation increase. Undoubtedly there are coexisting vascular changes in the smaller vessels and to some extent changes in fluid exchange and water balance; such changes have been described. Other types of cephalalgia probably have a similar method of pain production—histamine cephalgeas and Meniere's syndrome. Miles Atchison has demonstrated a relationship between Meniere's syndrome and migraine.

The mechanism of allergic reactions is largely based on vasomotor changes but has not been so definitely concerned with the amplitude of vascular oscillation. Undoubtedly allergy plays a part in production of migraine and a small percentage of such headaches can be proven on the basis of a food sensitivity, but it seems more reasonable to assume that the patient with migraine has an inherently vulnerable vasomotor mechanism which may be excited by a variety of causes—a so-called trigger mechanism. This is, of course, true in many known allergic conditions.

In the study of a patient with migraine one should be concerned with the situation as a difficult diagnostic problem, giving consideration to any abnormality elicited from a careful history and examination. Certainly the presence of organic neurological lesions should be ruled out. Then there should be a careful evaluation of other possibilities, including other existing organic disease, psychogenic factors, malnutrition, anemia, and endocrine imbalance. The importance of the psychogenic factor has been repeatedly demonstrated in handling these cases, and in many instances the physician who handles well the psychoneurotics, now recognized as one having a good concept of psychosomatic medicine, will probably handle migraine cases more successfully than any one else.

An allergic investigation is simply one of several procedures in the study of the patient with migraine.

Skin testing and trial or elimination diets must be considered. For such a study skin testing falls far short of being adequate, and when it fails, elimination diets must be resorted to before dismissing the possibility of food allergy.

For symptomatic relief the use of narcotics should be restricted—certainly if there is a tendency toward increasing frequency of attacks.

Consideration should be given to making ergotrate effective. It may not relieve when given by mouth or intramuscularly and may give a dramatic result if given intravenously.

Some rather good results have been reported by Miles Atchison, who determines the patient's histamine sensitivity by skin test. Those showing a strongly positive reaction are treated with histamine and those showing minimal reaction are treated with nicotinic acid (not the amide, the vasodilatory action of nicotinic acid is necessary).

The Mayo group has reported good results in treating the so-called histamine encephalalgia with histamine. The mechanism of pain in this type of headache is undoubtedly similar to pain in migraine.

It should be realized that such measures sometimes give rather lasting symptomatic relief and after other attempts have failed these measures are certainly justified; however, the fact remains that the important, truly scientific approach is the consideration of the patient as a diagnostic problem in internal medicine.

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INFECTED MICE HARBOR MENINGEAL DISEASE

The common house mouse, long believed to be a constant source of infection, was responsible for the illness of four persons in the same community who had a rare but mild disease known as choriomeningitis, according to three investigators writing in the May 4 issue of *The Journal of the American Medical Association.*

Gilbert Dalldorf, M. D., from the Division of Laboratories and Research, New York State Department of Health, Albany; C. W. Jungeblut, M. D., from the Department of Bacteriology, Columbia University College of Physicians and Surgeons, New York; and Margaret Douglass Umphlet, B. S., M. A., of Raleigh, N. C., say that "many house mice trapped in the homes of choriomeningitis patients are virus carriers and infection in experimental mouse colonies may persist indefinitely, being transmitted from one generation to the next. These observations suggest that a building harboring infected mice could be a persistent source of human disease."

The authors report 3 cases of choriomeningitis which developed among the residents of a multiple family dwelling in a North Carolina community, and a fourth case in a near neighbor. Two mice trapped in this building were found to be carriers of the virus causing this disease.

Choriomeningitis is marked by infection of the upper respiratory tract with symptoms of irritation of the meninges, or lining of the spinal cord, such as fever, headache and stiff neck. The disease lasts from ten days to two weeks, and recovery is almost certain.

DIAGNOSIS OF LIVER ABSCESS BY MEANS OF THOROTRAST HEPATOSPLENOGRAPHY

ROBERT J. REEVES, M. D.
and
KARL A. YOUNGSTROM, M. D.*
DURHAM, N. C.

Much has been written on the subject of hepatic abscess, but the importance of early diagnosis and treatment should be ever kept in mind. Ochsner[3] has very thoroughly reviewed the literature in his studies of amebic infection and liver abscess. The occurrence of liver abscess is becoming more prevalent and the early diagnosis by all possible methods cannot be stressed too much. The majority of hepatic abscesses are due to Endamoeba histolytica and since millions of our military personnel have been engaged in regions geographically and hygienically favorable to the maintenance of amebiasis, there is an obvious probability of a greatly increased incidence of amebic infection in this country. Figures on the incidence of amebiasis in the United States reveal no predilection for tropical and subtropical regions. Craig[1] stated that at least 13,000,000 people in the United States harbor the pathogenic intestinal protozoa. He said the highest incidence of liver abscess is found in amebiasis. He reported 84 per cent post mortem cases showing abscess. Amebic abscess of the liver was found on numerous occasions in which it was totally unsuspected before death.

The pathogenesis of liver abscess is well known. The infection is predominantly in the male sex. It is a condition of adult life, between 20 and 50 years of age. In our series only 3 cases out of 39 were female.

ETIOLOGY OF LIVER ABSCESS—OCHSNER

1. Transportation of virulent organism through the portal vein from areas drained by the portal system.
   a. Appendix.
   b. Rectum.
   c. Other portions of the bowel.
2. Extension from contiguous diseased processes.
   a. Cholecystitis and cholangitis.
   b. Gastric and duodenal ulceration.
   c. Subphrenic space infection.
3. Trauma.
   a. Penetrating injuries with introduction of microorganisms from without.
   b. Subcutaneous injuries producing devitalization of liver tissue permitting growth of microorganisms already present in the liver.
4. Blood borne infections with the production of metastatic abscesses, the microorganisms being transported through the hepatic arteries.
5. Amebic infection. This is the more common infection.

PATHOLOGIC MANIFESTATIONS

There is considerable variation in the gross appearance of the liver in amebic abscess depending on the location and the degree and stage of development. Usually the liver is enlarged, although if the abscess is small and deeply situated, it may have a fairly normal external appearance. If the abscess lies near the capsule, there is usually localized peritonitis with fibrinous exudation present on the surface. If the abscess is located in the dome of the liver, there are adhesions to the diaphragm and a bulging upward. Many of these cases go undiagnosed until there is a rupture through the diaphragm. The large chronic abscesses have a hard, dense fibrous shell, and it is frequently extremely difficult to demonstrate the amebae. In our series of 14 cases diagnosed amebic abscess, the organism was demonstrated in only 6. In 1 case the organisms were almost missed at autopsy, which is certainly a significant commentary on the difficulty of obtaining this important proof of the diagnosis.

DIAGNOSIS

The diagnosis of liver abscess, pyogenic or amebic, is not difficult if the conditions are kept in mind and clinical manifestations and laboratory examinations accorded due consideration. Amebic abscess should always be considered in a patient presenting a low grade daily remittent or intermittent fever, pain, and tenderness over the liver area. In many cases there is little or no jaundice. Chills and fever are more common in the pyogenic abscess. Repeated stool examinations should be made in the search for Endamoeba histolytica.

Differential diagnosis includes the cysts, metastatic tumor nodules, and the primary tumors, such as:

1. Hepatomas.
   a. Liver cell adenomas.
   b. Liver cell carcinomas with or without cirrhosis.
2. Cholangiomas.
   a. Carcinomas.
   b. Adenomas of intrahepatic bile ducts, solid or cystic.

From the Department of Radiology, Duke University College of Medicine.
Read before the General Meeting, State Medical Association of Texas, Annual Session, Galveston, May 9, 1946.
*At present in the armed services.

3. Cholangiohepatomas of both liver cell and duct elements.

4. Tumors primary in the liver but not of specific hepatic elements (vascular, fibrous, adrenal rests, and so forth).

Many of these cases are diagnosed by the surgeon but in addition to the clinical picture the characteristic fluoroscopic and roentgenologic observations must be evaluated. The liver is observed to be enlarged, the diaphragm elevated, and occasionally subdiaphragmatic or supradiaphragmatic extension is noted. Frequently the abscess is central and in the early stage may show no marked enlargement.

we have been unable to find any proof that the low grade radioactivity has produced liver damage or been a cause of death.

Thorotrast hepatosplenography should be reserved for patients where a real and useful diagnostic response can be expected. Undoubtedly the tissues react to the impregnation of thorium with changes which may in part be irreversible, but to the present time no clinical observations have been presented which allow acceptance of a veritable damaging action by thorium dioxide on the healthy organism or during the course of any disease.

FIG. 1a. CASE 1. Large abscess cavity involving upper half of the liver.

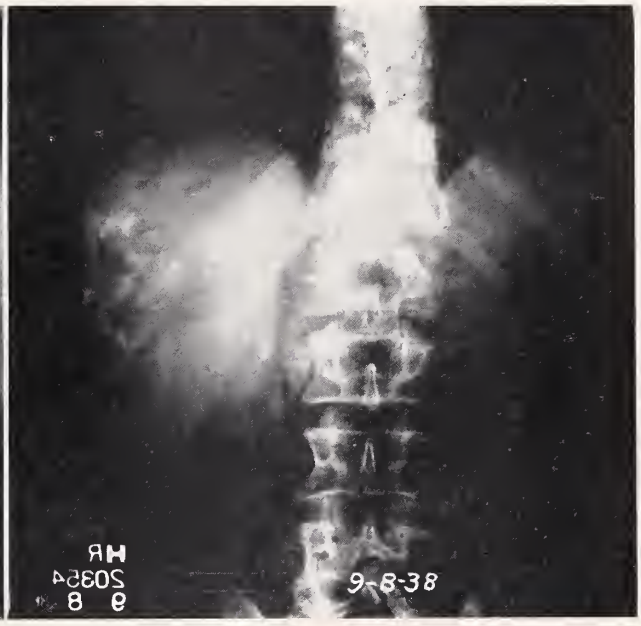

FIG. 1b. CASE 1. Appearance of the liver six years after injection of thorotrast. Most of the thorium has left the liver.

In this latter group the use of thorium dioxide is a most valuable aid in localization. In a former report,[6] in 1937, we discussed radioactivity of thorium, but there have been many reports on the use of this drug and pathological studies have failed to show any liver damage.[8] There is slow excretion and it is not known just when the drug is finally eliminated. Two of our cases showed disappearance of thorium by roentgen-ray in five and seven years, with no evidence of radioactivity recorded on the Geiger counter.

The use of thorotrast as a diagnostic procedure was discussed in a previous report,[5] but during recent years there has been neglect in the use of this method. The dangers in the use of thorium dioxide and its rate of elimination from the liver have been carefully studied.[4, 7] To this date, fourteen years after treating some of these patients,

Yater,[9] in 1944, gave the most recent report on the use of thorotrast.

The technique of injection of thorotrast is very simple. The average dosage is 75 cc. colloidol thorium dioxide mixed with several hundred cubic centimeters of isotonic solution of sodium chloride. It is injected slowly over a thirty minute period. The reaction, if any, is very mild. In making the injection it is important to avoid infiltration in the subcutaneous tissues. The thorium is not absorbed and produces a hard painful mass. The immediate presence of thorium is noted in the liver several hours after injection. A roentgenogram taken a few hours after injection often shows sufficient contrast to outline a cavity or mass. Yater[9] stated he has been able to detect contrast fifteen minutes after injection. The concentration in the reticuloendothelial cells continues over several

weeks and the liver density increases. Since a liver abscess or tumor is devoid of active reticuloendothelial cells, it will contain none of the thorium dioxide and will be of lesser density than surrounding normal liver tissue. In this manner the abscess may be easily demonstrated and accurately localized.

In our series, amebic abscess was found to be the most common cause of liver abscess. Twenty cases of the series of 39 were thought to have amebic infection. There were 35 males and only 4 females. There were 2 patients under 21 years of age, being 15 and 17 years, respectively. The oldest was a man of 70 years.

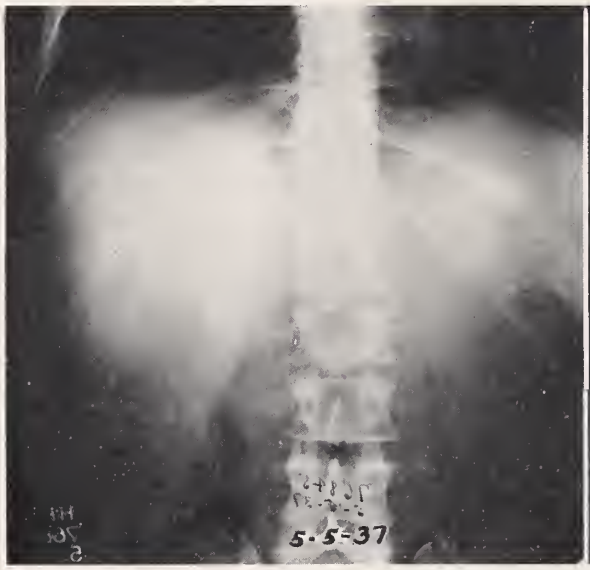

FIG. 2*a*. CASE 2. Liver appearance two weeks after injection of thorotrast. No cavity could be seen.

FIG. 2*b*. CASE 2. Liver now almost normal in size. There has been more concentration of thorium.

The following case histories serve to show the importance of localization of the abscess.

CASE REPORTS

CASE 1.—B. D., a white man, age 51, was admitted to the Medical Service complaining of pain below the right costal margin and diarrhea of seven weeks duration. Five years before admission, the patient began having bimonthly attacks of diarrhea and occasionally blood and mucus streaked stools. These attacks were mild and produced no great discomfort. Seven weeks prior to entry, the pain became severe and the diarrhea became worse. Stool examinations disclosed many motile ameba. A roentgenogram of the chest revealed a highly elevated right diaphragm and enlarged liver. These observations suggested liver abscess and a solution of 72 cc. of thorotrast was given intravenously. Roentgenograms disclosed a large abscess cavity, measuring 14 cm. in diameter (fig. 1*a*). The cavity was aspirated and 1,500 cc. of thick yellow pus was obtained. No organisms could be cultured.

The patient was placed on anti-amebic regime and appeared well until his death from heart disease six years later. A roentgenogram six years after initial thorotrast study showed most of the thorium had left the liver (fig. 1*b*).

CASE 2.—E. L., a white saw mill worker, age 35, was admitted to the Medical Service November 19, 1936, complaining of diarrhea for two months.

His past health had been fairly good except for typhoid fever at the age of 15. Since that time he had had episodes of summer diarrhea occurring every year or two. The stools at times had been bloody. No amebae were ever found.

His present illness was accompanied by a severe, bloody diarrhea which was intermittent and persisted to the time of his hospital visit. He had had no chills but felt hot at frequent intervals.

Laboratory studies revealed the white blood cell count as 17,000 with 82 per cent polymorphonuclears and 1 per cent eosinophiles. In one stool examination there were cyst-like forms which suggested amebae.

Proctoscopic study revealed small discrete ulcers but no amebae were found. Amebic infection was suspected, however, and the patient was given emetine hydrochloride, 64 mg. daily for six days. He improved rapidly following this treatment. The liver was found to be considerably enlarged. The clinician advised against thorotrast hepatosplenography and the patient was discharged.

He was readmitted April 14, 1937, with a history of chills and fever. He had been diagnosed as having malaria by his local physician and received treatment without relief. At this admission the temperature was spiking in character. The liver was moderately enlarged. He was again given emetine, 64 mg. daily for six days, and symptoms cleared up rapidly.

On May 19, he was given 75 cc. of thorotrast intravenously and a large liver was visualized (fig. 2). No abscess cavity could be found and exploratory surgery was not advised. After 25 mg. of carbazone, twice daily, was prescribed, he was discharged. When seen two years later he had had no further symptoms and appeared to be in good health.

CASE 3.—C. A., a white man, aged 37, was admitted to Duke Hospital February 21, 1945, complaining of chills and fever of five months duration.

The patient had been well except for a three

months episode of bloody diarrhea three years previously, which was diagnosed as amebic dysentery. He had received twelve intramuscular injections of some preparation and his symptoms had cleared up until October, 1944, when he began an intermittent fever and daily chills. He was thought to have malaria and was treated without relief. The temperature spiked at times to 104 F. An exploratory laparotomy at another hospital disclosed nothing abnormal. He was thought to have a kidney infection at that time.

Upon admission to Duke Hospital, his temperature was 101 F. The white blood count was 15,500. All other laboratory tests were negative. Roentgenograms of the chest and abdomen showed elevation of the right diaphragm and the liver margin was low. He was thought to have a liver abscess and was given emetine hydrochloride, 30 mg. hypodermically, for ten days. After his third hospital day he was afebrile and he was discharged to the outpatient clinic.

He was readmitted eight months later, October, 1945, with a similar story of recurrence of the chills and fever. His liver did not appear as large as at the former admission. He was given penicillin, 20,000 units every three hours, but the temperature continued spiking in character. On his thirteenth hospital day emetine, 30 mg. twice daily, was prescribed. His temperature returned to normal within six days and remained normal during his hospital stay. He was discharged but readmitted two weeks later with a recurrence of his former symptoms. At this time he was given 75 cc. of thorotrast intravenously. A roentgen film of the abdomen two days after giving thorium disclosed a large, 10 cm. abscess cavity in the upper, posterior portion of the liver (fig. 3*a*). This was given surgical drainage and thick, chocolate colored pus was obtained. All cultures were negative. His symptoms cleared rapidly and he was discharged to the outpatient clinic. A physical examination March 15, 1946, showed no evidence of infection. A roentgenogram of the liver region failed to show the abscess cavity and the liver had returned to normal size (fig. 3*b*). A study of the liver for radioactivity showed a count of fifteen on the Geiger counter, which is only slightly above normal.

FIG. 3*a*. CASE 3. After thorium injection of the liver, visualizing large liver abscess.

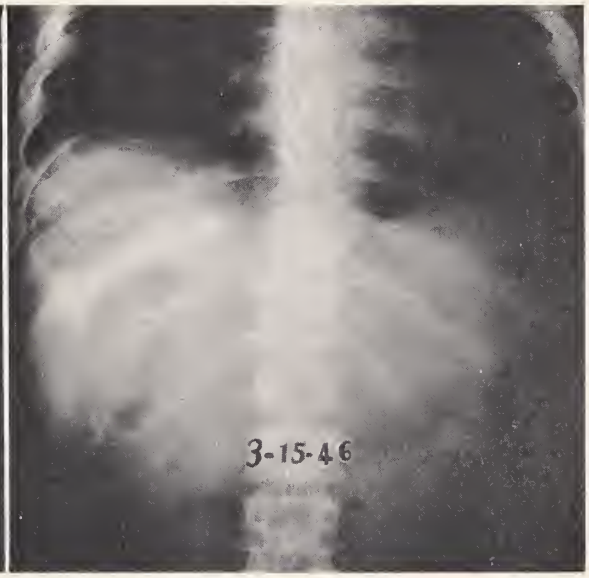

FIG. 3*b*. CASE 3. Follow-up study showing normal size liver and retention of thorium.

SUMMARY

The usefulness of hepatosplenography resides in the reliable demonstration of the size of the liver and spleen, and their internal architecture. In this way it is possible to solve important diagnostic therapeutic problems such as the presence or absence of abscess, cirrhosis, or tumor, and often to differentiate between these. One may also follow the progress of healing of a cavity or tumor metastasis under treatment. There is apparently no more reliable laboratory method short of operation to differentiate between carcinoma and cirrhosis in an enlarged liver. It is no small comfort to a surgeon to know the exact location of a liver abscess, its size, and relations, before drainage is attempted.

Pyogenic abscess is primarily a complication of an intra-abdominal suppurative process with the causative organism in the portal area. Of these lesions appendicitis is the most frequent. The most frequently found organisms in the pyogenic hepatic abscesses are B. coli, and Staphylococci. Amebic abscess is the most common cause of liver abscess in our study.

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PARA-AMINOBENZOIC ACID IN THE TREATMENT OF ENDEMIC TYPHUS FEVER

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Experimental investigations[1, 4, 7] have shown that para-aminobenzoic acid inhibits the growth of the rickettsiae responsible for typhus and Rocky Mountain spotted fever. The successful use of para-aminobenzoic acid has been reported in an epidemic of louse borne typhus fever,[8] and recently a case of Rocky Mountain spotted fever[6] was reported cured by the use of this drug.

Typhus fever of the murine type has been known to be endemic in Texas since 1916,[5] and since 1939[3] the case incidence has increased from 5 cases per hundred thousand to 30 cases per hundred thousand in 1945.[2]

The following report of 6 cases of endemic typhus fever of the murine type treated with para-aminobenzoic acid is so far as we know the first such report made.

CASE REPORTS

CASE 1.—A. W. Z., a white man aged 43, was admitted to the hospital on March 5, 1945, complaining of chills, fever, and generalized aching of two days duration. A physical examination was negative except for a macular rash present on his body.

On admission, the patient's temperature was 104 F. His complete blood count and urine were within normal limits, but his Weil-Felix reaction (Proteus O X 19) was positive through 1:1,280 dilution.

Para-aminobenzoic acid, 2 Gm. three times daily, was started on March 8. The patient's temperature had ranged between 102 and 104 F. before administration of the drug but dropped to normal on March 12. The patient was free of fever, headache, and felt fine. He received a total dosage of 66 Gm. with no untoward effects. The highest para-aminobenzoic acid blood level obtained was 1 mg. per 100 cc. The patient was discharged on March 19, recovered.

CASE 2.—R. N. A., a white man aged 39, was admitted to the hospital on December 29, 1945, complaining of "fever, chills, headaches, and all my bones ache" for nine days. He had received "a sulfa drug" but without results. His temperature had ranged between 100 and 101 F. during the day and up to 104 F. during the night. He had experienced no respiratory symptoms and physical examination was negative except for his acutely ill appearance and a fading macular rash present on his abdomen.

On admission, his temperature was 103.2 F. His white blood cell count was 7,450 and urinalysis was normal, but the Weil-Felix reaction (Proteus O X 19) was positive through 1:160 dilution. It continued to rise to 1:1,280-1:2,560 and up to 1:40,960 dilution even after medication with para-aminobenzoic acid had been started.

The dosage administered was 2 Gm. every two hours, started on December 31. The patient's temperature had ranged between 101 and 102 F. before administration of the drug. His temperature dropped rapidly to normal by January 1, 1946, at which time he was relieved of headaches, chills, and felt much better generally. He received a total dosage of 240 Gm. with no side effects. The highest para-aminobenzoic acid blood level obtained was 3.0 mg. per 100 cc. The patient was discharged on March 15, recovered.

CASE 3.—P. S., a Negro man aged 45, was admitted to the hospital on October 14, 1945, acutely ill, complaining of "fever, chills, and severe headaches" of four days duration. A physical examination was entirely negative.

On admission, his temperature was 102 F. The white blood cell count was 9,000 and urinalysis normal. Serologic tests were positive and the Weil-Felix reaction (Proteus O X 19) was positive through 1:160 and later 1:1,280 dilution.

Para-aminobenzoic acid, 2 Gm. every two hours, was started on October 17. The patient's temperature had ranged between 101 and 102 F. before the administration of the drug but had returned to normal by October 20. The patient was free of all his constitutional symptoms and felt well. He had received a total dosage of 168 Gm. with no toxic effects. The highest blood level obtained was 1 mg. per 100 cc. The patient was dismissed on October 25, recovered.

CASE 4.—E. M. W., a white man aged 25, was admitted to the hospital on July 21, 1945, complaining of "chills, fever, and abdominal pain for three days." Physical examination revealed an acutely ill young man with an enlarged tender spleen. On the third hospital day, his abdomen showed a macular rash which disappeared three days later. The patient received sulfadiazine because it was thought at first his symptoms were due to an upper respiratory infection, but there was no response.

On admission, his temperature was 104 F. His white blood cells ranged between 4,800 and 6,200, and repeated urinalyses were normal, but his positive Weil-Felix reaction (Proteus O X 19) rose steadily from 1:40 through 1:2,560 dilution.

Para-aminobenzoic acid, 2 Gm. every two hours, was started on July 25. The patient's temperature ranged between 100 and 104 F. before administration of the drug but had returned to normal by July 27, at which time the patient had been relieved of all his symptoms. The patient complained of being awakened for medication during the night, so on July 29, it was decided to give 2 Gm. every two hours from 8 a. m. to 10 p. m. His temperature returned to 102 F. for thirty-six hours, after which it returned to normal. He received a total dosage of 232 Gm. with no side effects. No para-aminobenzoic acid blood levels were taken. The patient was discharged on August 6, recovered.

CASE 5.—J. B. L. B., a white man aged 42, was admitted to the hospital on July 18, 1945, complaining of headaches, chills, and fever of three days duration. Physical examination revealed enlarged cervical glands and a palpable nontender spleen.

On admission, the patient's temperature was 102 F. His white blood cell count was 13,050, and the urinalysis was consistent with a low grade urinary in-

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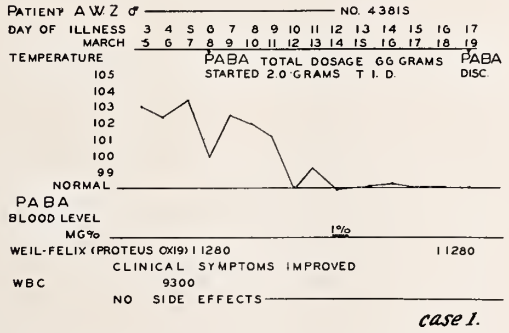
fection. Serologic studies were negative but his positive Weil-Felix reaction (Proteus O X 19) rose from 1:1,280 through 1:40,960 dilution.

Para-aminobenzoic acid, 2 Gm. every two hours, was started on July 21. The patient's temperature had ranged between 99 and 102 F. before the para-aminobenzoic acid was started. On July 22 his temperature returned to normal, at which time he improved clinically. He received a total dosage of 144 Gm. No blood levels were obtained. The patient was discharged on July 27, recovered.

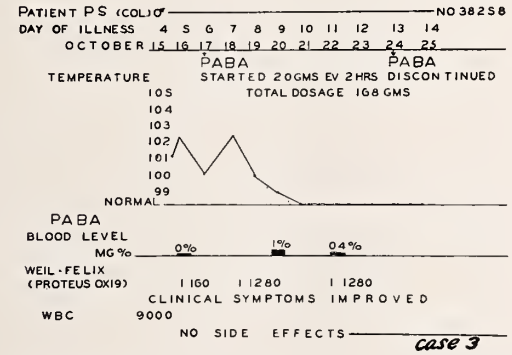
CASE 6.—G. A. G., a Negro boy aged 16, was admitted to the hospital on August 2, 1945, complaining of chills, fever, headaches, and vague abdominal pain of five to seven days duration. Physical examination revealed an acutely ill boy with fibrillary twitchings of facial muscles and generalized abdominal tenderness. The physical examination was otherwise negative.

On admission, the patient's temperature was 100 F. and rose rapidly to 105 F. The white blood cell count ranged between 5,000 and 6,700; the urinalysis was normal; but the Weil-Felix reaction (Proteus O X 19) was positive through 1:320 dilution and continued to rise to 1:20,480.

Para-aminobenzoic acid, 2 Gm. every two hours, was started on July 7. The patient's temperature had previously ranged between 102 and 104 F. but fell to normal by July 9. His headaches and generalized pains disappeared at this time. He received a total dosage of 168 Gm. without any side effects. A para-aminobenzoic acid blood level of 8.8 mg. per 100 cc. was obtained. The patient was discharged on August 16, recovered.



case 1.



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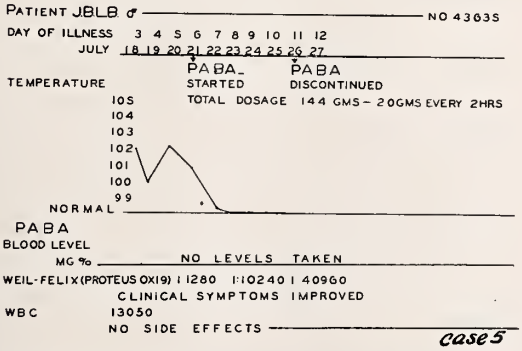

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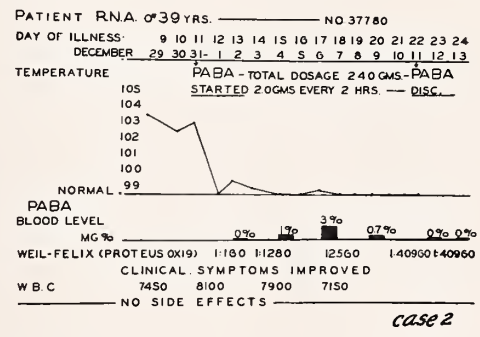

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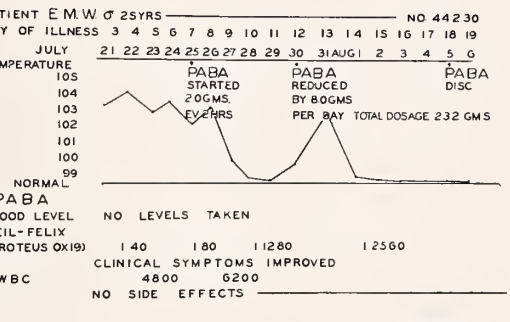

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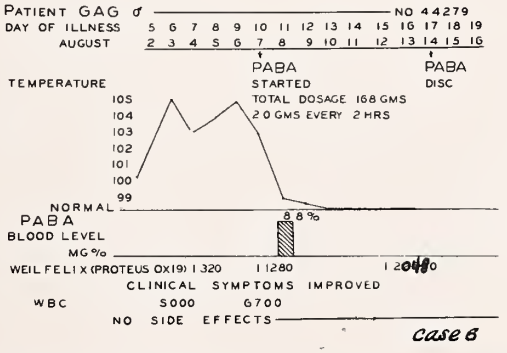

case 6

COMMENT

The 6 cases reported have been observed in the Medical Service of the Southern Pacific Hospital in Houston, Texas. The diagnosis was made on clinical symptoms and findings and by the determination of the Weil-Felix reaction with B. Proteus O X 19. Extremely high titers were noted in the cases reported, two reaching a titer of 1:40,960. This serum was checked and the reading found correct.

The blood levels of para-aminobenzoic acid in these cases were considerably lower than those reported by Yeomans and others.[8]

This may have been due to the fact that the initial priming of the blood with large doses of para-aminobenzoic acid as recommended by Yeomans and his associates,[8] namely 4 to 8 Gm., was not followed in these cases. Because of the rapid elimination of para-aminobenzoic acid from the system Yeomans[8] advised that 2 Gm. be given every two hours around the clock, and in the cases reported here this was not the procedure in all instances. The response that has been noted by us seemed rather dramatic, even with the essentially lower blood levels of the drug. It is assumed that good results may be obtainable with lower blood levels as has been observed in the use of the sulfonamides. It should be stressed that even with the large doses of the drug used, no untoward side effects were observed in either the blood or urine. Yeomans[8] reported an occasional leukopenia, which might have been a result of the high blood levels he obtained.

SUMMARY

Six cases of endemic murine typhus are reported, which responded favorably to para-aminobenzoic acid medication. The drop in temperature and relief of symptoms were almost dramatic in their effect. No side effects in the use of the drug were noted. It is hoped that with the prevalence of typhus fever in this area, more observations will be made on the use of para-aminobenzoic acid as a means of therapy.

We wish to acknowledge with thanks the assistance of the Art Department of the Baylor University School of Medicine, for preparation of the charts.

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Health is not an inalienable right. It is a privilege. Privileges invariably entail equivalent responsibilities. It is so easy to accept privileges that before long mankind takes them for granted and claims them for inherent rights. Nature grants few rights, preferring to demand that privileges be earned. Health, like freedom and peace, continues only as we exert ourselves wisely to maintain it.—Edward J. Stieglitz, M. D., A Future for Preventive Medicine.

PROSTIGMINE USAGE IN PEDIATRICS

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This discussion is to review the possibilities, as well as the limitations, of the much heralded drug prostigmine.

In the first place, what is prostigmine and what is its pharmacological effect when administered to the human system? Prostigmine is a synthetic compound resembling physostigmine (eserine).

Its pharmacological effect is vagatonic, but not attended usually by side reactions. It inhibits the destruction of acetylcholine by cholinesterase, which property offers the greatest benefits by affording a better transmission of nerve impulses across the myoneurol junction, thereby enhancing cholinergic action by maintaining a maximum of body acetylcholine. A further advantageous result is a mild spinal cord depressant action, which assists in relaxing the spastic muscles, thus increasing the comfort of the patient and the possibilities of muscle training.

To date the drug has been tried in a variety of conditions, principally in the pediatric field.

First in the list of conditions so treated is myasthenia gravis. Prostigmine has been used extensively in the acute stages of poliomyelitis, more extensively in subacute and chronic polio. It has been used with varying effect in chronic spastic conditions due to cerebral hemorrhage of the newborn. Probably most important of all, it has been found effective in some conditions involving the intracranial nerves, especially cases of hearing loss and some cases of optic disturbance.

The two salts of the drug are prostigmine bromide, administered orally, and prostigmine methylsulfate, by intramusclar injection. Oral prostigmine bromide seems to be the choice drug in acute poliomyelitis and in conditions involving the intracranial system. The dosage ranges from two to four 15 mg. tablets daily. It is preferable to administer a moderate dose of atropin sulphate to counteract the depressing effect on the spinal cord where this action is not desirable.

Prostigmine methylsulfate is commonly employed in the treatment of myasthenia gravis and in spastics.

The drug for parenteral use is in two strengths: 1:2,000 containing .5 mg. of the drug; 1:4,000 containing .25 mg. Injections are usually administered twice weekly for a

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varying period, depending upon results obtained, and usually for several months.

The following reports have been gleaned from recent literature.

(*Herman Kabat*).[4]—Dr. Kabat states that *(Herman Kabat)*.[4]—Dr. Kabat states that prostigmine decreases muscle spasm and inhibits incoördination in acute and chronic poliomyelitis, and brings about acceleration of recovery in polio, and that improvements obtained are permanent. He also discusses the use of the drug in rheumatoid arthritis and in spastic cerebral palsy. Of 430 patients with various types of neuromuscular disability who have been treated, a majority have been significantly benefited and a few have been benefited drastically. Dr. Kabat states that the duration of the disability makes little difference in the prognosis. The drug, he says, brings relief in a large number of cases regardless of the etiological factor. His routine procedure has been in general .5 mg. daily to twice weekly by injection and 30 to 60 mg. daily orally. In practically all cases no untoward effects were seen and the patients went about their usual daily habits. Dr. Kabat reports a group of 10 spastic paralysis patients, none of whom had understandable speech in spite of much phonetic training, who were treated eight months with this therapy. All were improved greatly as to their ambulatory troubles, and 9 of the 10 could carry on understandable conversation. Before treatment, all had to be fed by an attendant. After four months, 9 could feed themselves fairly well.

Drs. Kabat and Knapp were probably first to use prostigmine in polio extensively, followed soon by Drs. Boines, Eveleth, and Ryan. All agree that prostigmine has remarkable value in subacute and chronic cases, to wit: it relaxes muscle spasm, increases range of motion, causes deformities to improve or disappear, improves coördination, increases strength, and relieves fatigue.

Furthermore, definite results may be obtained even many years after the acute infection. Obviously special muscle training measures should not be neglected.

The physicians named all agree that the value of the drug in acute polio is subject to debate and further study.

Neostigmine in Acute Anterior Poliomyelitis (M. J. Fox and W. K. Spankus).[2]—The author reasoned that since Kabat and Knapp had reported good effects in prostigmine treatment of subacute and chronic polio, its advantages in acute polio should be sought. Their cases were definitely diagnosed by the usual methods and consisted of 24 cases of 5.5 days average standing.

Their conclusions are as follows:

1. Prostigmine produces a partial relaxation of the spastic muscles in a majority of cases. This relaxation is not dramatic, not constant, and not lasting.
2. The combined use of prostigmine and local therapy, such as the Kinney treatment, results in most cases in a perceptible persistent relaxation of spastic muscles, and this combined therapy is definitely warranted.
3. The drug appears to be of little value in bulbar poliomyelitis.

Management of Infantile Cerebral Paralysis (Paul N. Jepson).[3]—Dr. Jepson reports on 25 cases of infantile cerebral paralysis treated with oral prostigmine. He concludes there is sufficient evidence to warrant the continued use of prostigmine. Some beneficial results were observed in all cases, remarkable results in a large percentage. He observes further that those treated between the ages of 1 and 4 years show a much greater degree of improvement than those treated after the age of 4.

Treatment of Deafness and Contiguous Nerve Disorders (I. Carroll Davis and John C. Rommel).[1]—In the autumn of 1936, the writers began the use of prostigmine hypodermically in treating deafness. It improved the hearing exceptionally in some patients. Patients with early catarrhal deafness often recovered remarkably after four or five injections. They, therefore, conclude that prostigmine is a valuable remedy for deafness.

They at first tried oral prostigmine alone, but later found that better results were obtained when concurrent subcutaneous treatment was given.

The authors report 24 cases of chronic deafness under combined treatment. Good recovery of hearing was obtained in 7, satisfactory improvement in 6, slight improvement in 9. One patient had a concurrent trigeminal neuralgia which was entirely relieved.

Most of these cases were of so-called catarrhal deafness and the authors suggest that general otological measures of relief should not be neglected, along with prostigmine therapy.

Effect on Hearing Loss and Tinnitus (Henry D. Taterka).[7]—Since Dr. Taterka's discussion on the value of treatment in hearing loss was not followed by audiometric studies, I shall present his conclusions only:

1. Prostigmine has proved of definite value in the treatment of tinnitus as an otological symptom and merits further investigation.
2. The effect on hearing, which was noted

during treatment, merits further study with accurate audiometric determination.

3. Of 21 patients 12 were definitely improved.

4. It is interesting to note that of the 3 cases diagnosed as otosclerosis, all reported definite improvement.

5. While all patients were not helped, no other single remedy or combination of remedies has proved so satisfactory.

Treatment of Spastic Cerebral Palsy (H. J. Schaubel).[6]—Prostigmine is a valuable adjunct to the muscle and phonetic training program in spastic cerebral palsy. Schaubel reports eight months treatment of 10 tetraplegias, ages 6 to 14 years, who responded to treatment from a group of 32. Oral treatment only, using prostigmine bromide, dosage adjusted to age was given. Improvement was observed in severe as well as in mild cases. All 10 were unable to talk. Six weeks medication found 3 able to utter understandable words, and at the end of the eight months period, with concurrent phonetic training, only 1 had residual speech difficulty. Prostigmine seemed also responsible for a decrease in muscle spasm with a marked degree of improved locomotion. Seven subjects who had never walked without the aid of walking bars were enabled to walk with crutches only. The other 3, formerly capable of no type of ambulation, were able to operate mobile walkers. Eventually, he states, 6 have become able to walk without artificial aid. All 10 who responded to treatment, unable prior to treatment to feed themselves, became able to do so. No bad effects were noted in any.

Use for Impaired Hearing (Morris Rosenthal).[5]—Over a period of years 24 cases of hearing loss were treated, 6 patients with hearing impairment of only a few months. Audiometric determination was made in establishing conclusions. Results of treatment were summarized as follows: 19 patients showed objective improvement; 16 showed subjective improvement; 9 showed no improvement; 11 showed objective improvement in all frequencies.

This particular observation was noted: objectively, that is, judging from the audiometric readings, practically all patients were improved. However, those patients with the lower decibel hearing loss, 35 or under, even though receiving but a 5 decibel improvement, reported subjective relief, while those with a naturally high decibel loss, though improved 10 decibels or more, showed insufficient improvement for subjective relief.

The following cases are from personal observation:

CASE REPORTS

CASE 1.—Five patients, ages 2 to 7 years, with acute poliomyelitis definitely diagnosed by the usual methods, were given 10 mg. prostigmine bromide every eight hours in conjunction with other general nursing measures. Muscle spasm was never severe in any of the patients, 4 recovered completely, 1 has a residual mild unilateral shoulder drop.

CASE 2.—L. M., a boy, age 6, developed acute encephalitis following an obstinate attack of tonsillitis. After ten days, sequelae consisted of partial paralysis (spastic in type) of one forearm and almost total blindness. After these symptoms had continued unabated for a period of ten days, 45 mg. prostigmine was given daily orally. After four days improvement was marked; in eight more days the forearm became usable and sight was good enough to allow him to distinguish persons. At present, after two months treatment, the residual trouble in the arm is only moderate and the child can distinguish letters from fine print. This case was so fantastic I hardly feel justified in drawing any definite conclusions.

CASE 3.—R. A., a boy of 5 years, had spastic paralysis caused by apparent cerebral hemorrhage at birth. Paralysis involved both arms and both legs. He was unable to speak any understandable words. There was no impairment of hearing. He has had eighteen weekly injections of prostigmine, .5 mg. each, with 30 mg. orally each day. Now he is able to speak some understandable words and is being taught with remarkable success by a speech training teacher. Muscle coördination is definitely improved.

CASE 4.—J. M., a girl 6 years of age, had spastic paraplegia with mild spastic speech, and incoördinate movement of hands and face. After the third dose of prostigmine her teacher reported practical cessation of incoördinate movements of hands and face. The mother says she handles large words and is decidedly more normal mentally. At office examination, all the improvements were objectively found to be correct. A year trial on tricycle riding had failed. Now she rides handily. April 15, after two months treatment, the child is rapidly approaching normal.

CASE 5.—M. C., a 6 year old boy, when 3 days old, had convulsions. He then developed properly until he had recurrent acute cerebral hemorrhages at the age of 15 months. He lost his speech and became a poorly walking spastic. After four weeks of combined prostigmine treatment, his speech is better and he walks better. He had a badly needed circumcision under general anesthetic without any untoward event. The mother says the child is more natural and pleasurable, too. This is a rather severe case. Vitamin K and calcium are being given to combat possible recurrent hemorrhage. No cause can be found to account for the pathologic condition. The prognosis is not too promising.

CASE 6.—W. J., a 4 year old boy, with spastic speech, drools constantly, and has very large tonsils and signs of adenoids. Prostigmine treatment was begun with .5 mg. injection weekly and prostigmine bromide by mouth, 30 mg. daily. Three weeks later, the boy's teacher reported remarkable results. March 5, a tonsillectomy-adenoidectomy was performed with uneventful recovery. The boy said "bye-bye" and "thank you" normally. Drooling had completely ceased. April 17, after two months treatment, the child uses better speech, shows a changed behavior, and feeds himself. The parents are thoroughly overjoyed with the results.

CASE 7.—F. S., a boy 6 years old, showed mental deficiency and speech aphasia. He was able to speak some understandable words. Encephalitis spastic paraplegia was the diagnosis. He was barely able to walk alone, and was usually supported by his parents. His facial expression was very disturbed. After one month of weekly injections of prostigmine

and 30 mg. daily by mouth, he is actually able to skip unsupported, puts words together, and counts 1 to 10 with perfect diction. It appears that encouraging changes are to be expected in this young boy.

CASE 8.—J. C., a girl 4 years of age, had congenital deafness. After four weeks of .5 mg. prostigmine weekly by injection, 15 mg. nightly by mouth, the speech teacher feels there is a degree of acceleration in speech activity. No conclusive evidence concerning improvement of hearing is available.

CASE 9.—S. W., a girl 4 years old, showed a spastic speech pattern speaking single words. Her history revealed encephalitis at 1 year. Prostigmine injection and 15 mg. daily by mouth were begun. After three weeks, she was attempting new words. After three more weeks, her vocabulary and speech articulation are definitely improved. Soon she is to enter a speech training school for the first time.

CASE 10.—R. W., a girl 2.5 years old, had typical Little's disease. March 5, 1946, she was given a fourth injection of prostigmine and prostigmine was started by mouth, 15 mg. doses. There were no immediate results. March 26, she crept for the first time in her life. April 15, she showed no further improvement and the prognosis is quite doubtful.

CASE 11.—M. R., a girl age 8 years, had congenital early deafness. Under the usual treatment for two months her hearing ability has definitely improved. She answers the mother's call from an adjoining room for the first time in her life. Her speech enunciation is very nearly normal. Speech training will, of course, be continued.

Three other cases of congenital deafness are under treatment but for too short a period to warrant a preliminary appraisal of the drug's value.

Likewise, under treatment and observation are 19 other cases of varied types of spastics. Some optimistic signs are already evident, though the patients have been under treatment for less than three months.

CONCLUSIONS

I admit that results with prostigmine are limited and not too promising but they are worth utmost consideration in pediatric cases in which heretofore there has been practically no promise.

I do not join the over optimistic in this limited report of experience, but there seems little doubt that some real and lasting results through a course of several months longer will be seen.

Certainly a large number of these patients, in fact a large majority, will derive no benefit, but the evidence that it is of value in some is convincing. The use of prostigmine in such pediatrics cases is well worth a thorough trial.

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ABSTRACT OF DISCUSSION

Dr. James H. Park, Jr., Houston: Before the introduction of prostigmine as an adjunct in the treatment of spastic paralysis in childhood, the results were unsatisfactory and discouraging to the patient, the parents, and the physician. Prostigmine is a therapeutic agent which assists by lessening or actually abolishing spasticity of muscles. That helps the patient to relax and permits of more coördinated movements of the extremities.

It seems to work best in those patients under 10 years of age. While it is by no means a "cure-all" or miracle drug, as certain newspapers and periodicals would have the laity believe, the literature justifies its continued usage in the therapy of spasticity of muscles, especially of the infantile cerebral type. Lately, improvement in nerve deafness after its use has been reported by some observers.

In that connection, a 3.5 year old male patient of mine, who recently recovered from an acute pneumococcic meningitis after two relapses of the disease, developed bilateral nerve deafness. He will be given whatever advantages the drug may hold in store for him.

Those who have had the most experience with prostigmine in the conditions under discussion emphasize the importance of giving it in adequate dosage for three to six months or until improvement can no longer be demonstrated.

Two or more weeks may be required before definite improvement can be detected. A white boy 14 years of age, at Hermann Hospital, who exhibited rheumatoid arthritis, was given .5 mg. of prostigmine methylsulfate and atropin sulfate 1/150 grain every eight hours for three or four weeks. He also received the customary physiotherapy. Slight improvement was noted. Prostigmine was then discontinued. The boy's muscles soon became stiff and painful again. He requested that the hypodermic administration of prostigmine be resumed. It was, with immediate relief.

Reports such as the essayist has presented serve as an incentive to further studies by others, which should lead to the standardization and proper evaluation of prostigmine therapy in pediatrics.

"SHELL SHOCK" DECREASED IN WORLD WAR II

Hysteria, the "shell shock" of World War I, was greatly decreased in World War II, according to the Surgeon General's office. At the time of the first war hysteric conditions in which a mental malady was manifested as a syndrome which simulated, without organic basis, some pathologic physical condition were common both among military personnel and civilians. Shortly after the war psychiatrists began to report that no hysterical patients were appearing, but that there was an increase of "anxiety neurosis," an overwhelming fear without specific physical manifestations. It was explained that the pattern of reaction of a person with a somewhat unstable nervous system was changing with the changing times, and that hysteria was a disease of a simpler environment. In the war just past, the changed reaction persisted, and a study by David B. Davis and John W. Bick of the Army Medical Corps indicates that only about 1 out of 5 of more than 1,000 neuropsychiatric patients returned to one American Army hospital from overseas was a victim of hysteria.—S. G. O. Notes, July 31, 1946.

WATER IN RELATION TO HEALTH PROBLEMS IN CHILDREN IN TEXAS

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The problem of child health in Texas is particularly great and one which demands active effort on the part of physicians, public health workers, legislative bodies, and the general public. The magnitude of this problem was brought to my attention quite forcibly recently when it devolved upon me to discuss with the pediatricians of the country the subject of rheumatic fever and rheumatic heart disease as a child health problem in the United States. Rheumatic heart disease is one of the chief causes of death in children of school age. In 1940, for example, in children from 5 to 14 years of age this disorder caused more deaths than the combined fatalities from diphtheria, poliomyelitis, scarlet fever, measles, whooping cough, and meningococcic meningitis. In 1941 rheumatic fever was responsible for more deaths than all forms of tuberculosis in this particular age group. These rather startling statements stimulated consideration of child health in Texas from the comparative viewpoint. It was rather astounding to realize the quantitative relationship of these deaths in children. The total deaths in school age children for the entire United States attributed to rheumatic fever and rheumatic heart disease, tuberculosis, plus the common childhood diseases mentioned above, equal about one-half of what may be called unnecessary deaths in Texas children. For the years 1940 and 1941 more children died in Texas than in New York, and the latter state has somewhat over twice the population of our great state. According to vital statistics of the United States the deaths in children under 20 years in Texas and New York in round numbers, were 15,500 and 14,900 for 1937 and in 1941 they were 12,200 and 11,900 respectively.

This information is of value in order to determine the cause of these deaths so that attempts may be made to correct them. Last year I analyzed in a rather cursory way the disease conditions which contribute to the high death rate in Texas children. In the first place, it is particularly heartening to find that the over-all death rate in Texas has been decreasing remarkably in the past decades just as in the rest of the country. The decrease in typhoid fever deaths has been phenomenal. Furthermore, it is interesting to note that the crude death rates for such conditions as cancer, diabetes, exophthalmic goiter, chronic rheumatic disease of the heart, and heart disease in general are actually lower in Texas than in the United States as a whole. The rates for such conditions as meningitis, syphilis, infantile paralysis, acute rheumatic fever, and appendicitis are practically the same in Texas as for the country as a whole. Rather astounding is the fact that the rates for such easily preventable diseases in children as typhoid, diphtheria, whooping cough, and even tuberculosis are greater in Texas than in the United States as a whole. As is usual in various communities with high death rates for children, the conditions which contribute materially to these high rates are prematurity and particularly those conditions classed under the "diarrheas and enteritis." In these classifications the rate for Texas is twice that of the country as a whole.

It is virtually impossible to define precisely the exact role that water plays in the death rates in Texas children. This is true because certain diseases, such as typhoid and dysentery, may be water borne. Other diseases may be present because of excessive amounts of water which are conducive to a better breeding ground for mosquitoes in relation to malaria. In still other aspects the mineral content of the water, as for example, iodine and fluorine, may be of significance in the maintenance of a healthy state of the child. Water in relation to the health problem has been emphasized by many workers in the field of public health, especially in relation to man's external environment. Of special interest to the pediatrician and practicing physician, on the other hand, is water in relation to man's internal environment. In spite of the many careful scientific investigations in the field of water metabolism too little attention has been given to the quantitative significance of water requirements for infants and children.

One of the most significant features of human metabolism is that the water requirement for infants on the basis of weight is normally three times greater than that of adult subjects. In sick infants the relative requirement is even greater. In diarrhea one may attribute the real cause of death to an insufficiency of water. It is almost a conditioned reflex for physicians in prescribing for the infant with diarrhea to give as the first order "withhold all food" or "starve for twenty-four or forty-eight hours." Inasmuch as the natural food of infants is composed of seven-eighths parts water, withholding all food means that a negative water balance develops because of

From the Department of Pediatrics, University of Texas School of Medicine.
Read before the Section on Public Health, State Medical Association of Texas, Annual Session, Galveston, May 7, 1946.

(1) a decreased intake, (2) a loss of water through the stool, (3) an increased requirement due to enhanced metabolism existing with fever, and (4) the possible co-existence of vomiting. True enough, the advice "offer fluids such as water or weak tea" is given by the physician, but seldom is an exact idea of the quantitative value of these emphasized. Consequently, death often results in the infant with diarrhea because of dehydration, frequently with an acidosis. It was pointed out years ago by Rubner that a man may lose 40 per cent of his body weight, practically all of his stored fat and carbohydrates, and as much as one-half of his body protein and he may survive for a month or longer without all food. He cannot, however, survive without water for more than a few days and if one-fifth to one-fourth of the body weight is lost because of lack of water, death results. Hence, our number one consideration in the care of infants with diarrhea is to maintain proper water balance.

It appears that not only should all practicing physicians be familiar with water requirements for infants and children and know how to meet them, but likewise public health workers, hospital personnel, and the general public should be familiar with the quantitative significance of water in the maintenance of the health of children. Naturally it is not to be expected that these latter completely understand the field of water metabolism, inasmuch as it is indeed complicated. The relatively enormous water requirement for the infant severely ill with diarrhea might, however, be pointed out. From a comparative viewpoint a 150 pound man dehydrated to a similar degree as the infant with severe diarrhea would require 50 pounds of water in a twenty-four hour period. In the terms of flasks at a bedside ready for parenteral administration of fluid it is apparent that this amount is indeed startling. Nonetheless, the infant, because of his active metabolism, actually needs fluids in these amounts in order that body functions may not be impaired. By means of simple calculations we may assume that a previously healthy infant weighing 10 kg. because of severe diarrhea and inadequate fluid consumption loses 1.5 kg. This means that the fluid between the cells has practically disappeared, the circulating vascular system has become stagnant resulting in impaired kidney function, and in addition there will probably be ketosis due to an excessive burning of fat resulting from the lack of available carbohydrate. It is apparent that it is necessary to replenish this fluid loss. During the next twenty-four hours there might be additional loss of water with, of course, electrolytes in the stools which may amount to an additional 0.5 kg. As stated previously the normal fluid requirement for infants is in proportion far greater than for adults. In fact, in a twenty-four hour period the amount consumed equals 10 to 15 per cent of the body weight in children compared with but 2 to 4 per cent of the body weight per day in adult subjects. The normal quantity of fluid to be consumed by such an infant would be about 150 cc. per kilogram body weight or another 1.5 kg. To replenish completely the fluid loss and to meet his normal requirement would take then perhaps 3,000 to 3,500 cc. during the twenty-four hour period. Hence, it is apparent to replenish the body fluids would require supplying water and aqueous solution equivalent to 30 to 35 per cent of the body weight. How such fluid should be administered and the type of electrolyte preparations to be used requires the expert knowledge and ability of the practicing physician and his especial pediatric trained nurses.

The knowledge of water metabolism in the scientific field has been enhanced tremendously in the past decade; likewise the practical methods for the judicious use of fluids in clinical medicine have been increased. One of the distinct advances in the water and electrolyte field has been made by a pediatric colleague, Dr. Daniel C. Darrow, of Yale University. Water is inextricably related in its functions to electrolytes. For descriptive purposes, water within the body cells accounts for 50 per cent of the body weight and the electrolytes of especial significance here are potassium and phosphorus. The water in the other two compartments, namely the circulating vascular system and the so-called interstitial fluid compartments, comprises another 20 per cent of the body weight. The chief electrolytes in these compartments are sodium and chloride ions. No attempt will be made here to discuss the interrelationships between these ions; however, it may be pointed out that Darrow has found that in diarrhea along with the fluid and electrolyte loss which develops, a specific loss of potassium occurs from the body cells. Because of this loss of potassium from within the cells there occurs an increase of the sodium within the cells. This discovery is not only of great scientific significance but follow-up studies by Darrow have shown that this information is of practical value. In a personal communication Darrow stated that the administration of an isotonic electrolyte solution with the following composition: potassium chloride 2 Gm., sodium chloride 3 Gm., molar sodium lactate 40 cc., and water

710 cc., is of distinct advantage in the treatment of diarrhea. When this solution was administered quantitatively correct to infants with severe diarrhea in one outstanding medical center, there resulted a drop to but one-sixth of the previous mortality rate.

In a current communication Darrow revealed that in some cases during the recovery from the dehydration resulting from severe diarrhea there was evidence of a transfer of the sodium from extracellular to intracellular compartments when the usual solutions (containing sodium chloride, sodium lactate, and dextrose) were employed. This transfer of sodium resulted in even further loss of potassium from within the cells. The loss of potassium was excessive to the loss of nitrogen. He found further that when these sick infants are treated with isotonic fluids containing the potassium salt there is replenishment of both the intracellular and extracellular electrolytes and the babies look much better than after the usual type of treatment. However, the diarrhea per se was not affected by this regimen.

Darrow realizes there are many problems still to be worked out in the complete understanding of the water and electrolyte metabolism in relation to diarrhea. The University of Texas Child Health Program has invited Dr. Darrow and his associates to come to Texas this summer so that he may be able to continue these studies. The complete facilities of the Department of Pediatrics of the University of Texas School of Medicine will be available to him. Physicians caring for infants severely ill with diarrhea are invited to refer these sick infants to the Children's Hospital at the Medical School in Galveston.

In closing, it is apparent that some advantage has been taken of the subject of "water in relation to public health problems." It was felt, however, that emphasis of the significance of intrinsic water metabolism is of importance to all those interested in the public health. True enough, the knowledge of water metabolism in medicine in relation to problems of edema (renal, cardiac, or nutritional) or of the severe loss of water such as in diabetes insipidus should also be included in a complete discussion. In none of these disorders, however, is water so intimately related to the problem both from the viewpoint of the external environment and internal environment as in diarrhea. In fact, when a proper understanding of water metabolism in relation to diarrheal disease is realized by the general public, hospital personnel, and physicians, much will be accomplished in reducing the mortality of one of the major conditions which contribute to high death rate in the children of Texas.

ABSTRACT OF DISCUSSION

Dr. N. M. Atkins, Waco: It is a pleasure to discuss the presentation of Dr. Hansen. It is true that more children die in Texas than any other state in the union, although Texas is sixth in population. The morbidity and mortality rates are far too high for preventable diseases. Physicians know what has been accomplished with typhoid fever and smallpox; and yet, there are preventive measures for other diseases that have not been used for the protection of Texas children. Because of this, a high death rate in children continues. It is also true, that water borne diseases have been reduced to some extent by improved sanitation, but there is still room for considerable more improvement even in the larger cities and towns as well as in rural communities. A high morbidity and mortality rate will continue until the people can be educated, and this means some educated people must take advantage of the preventive measures now available.

Dr. L. P. Walter, Austin: I wish to congratulate Dr. Hansen on this excellent paper which proves that there are many major public health problems in Texas. Deaths from diarrhea and enteritis among infants have proved to be a major problem for many years especially among the Latin American population. During the summer months the large number of patients located on the Texas-Mexico border could easily fill many hospitals.

CLEANING TRAUMATIC WOUNDS BY MULTIPLE FINE-STREAM PRESSURE IRRIGATION—AN IMPROVED METHOD

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It is axiomatic that clean wounds heal promptly in minimum time and with maximum functional recovery. It is equally true that dirty wounds, those inadequately cleaned or not cleaned at all, develop infections of varying severity, and all such wounds heal slowly with prolonged morbidity and with less than maximum functional recovery.

The problem, then, is to convert every wound into a clean one, one free of foreign bodies and of bacteria. This is the ideal for which we should strive, and while no ultimate solution has been reached, a number of forward steps have been taken in this direction.

USUAL METHODS OF WOUND CLEANING

Irrigation.—This is a time-honored method and will always be acceptable. Mechanical flushing out of a wound by a gently flowing stream of water, saline solution, or other liquid does remove a rather large proportion of the gross particles of dirt and other foreign bodies that are not too tightly embedded in the soft tissues. But one can readily see that such a stream will not dislodge those finer particles that cling to the tissues even after using very large quantities of solution.

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The method of irrigation with a gently flowing stream therefore is admittedly inefficient and ineffective, and furthermore will carry particles from dirty zones into clean ones.

Brushing and Scrubbing.—Another well-established practice is gently to scrub, mop, or brush, whichever method one prefers, the contaminated area with a sterile soft brush, gauze sponge, or cotton ball while the irrigation above described is being carried out. This adds somewhat to the efficiency of the irrigation, but again it seems evident that the countless tiny particles embedded in the muscle fibers, between little fascial planes, and otherwise hidden from sight are untouched and left as foci of infection.

Local Chemotherapy.—Innumerable agents have been tried to produce sterilization of dirty wounds on local contact, but so far as I know none has yet succeeded. At first everyone thought that local application of the sulfa drugs would be the final answer, but it has proven a mirage. True enough, the sulfa drugs do have a definite effect when applied locally, but they are far from the goal surgeons seek. After all, though, "hope springs eternal," and perhaps some as yet untried substance will end the quest.

Debridement.—This has been developed to a very high degree through experience gained in two world wars. It removes all dirty and devitalized tissue by en bloc excision, and has been responsible for a great lowering of mortality. It is not and will not be replaced by pressure irrigation, but, as pointed out later, the two may often be used together to the advantage of the patient.

IMPROVED METHOD

In my approach to this problem an effort was made to reduce it to its simplest terms. What is the problem? Simply this: Bacteria constitute the only real difference between a clean and a dirty wound. There were no bacteria in a badly lacerated arm or leg just before the injury—the tissues were clean. Right after the injury bacteria *are* present, having been carried in on pieces of foreign bodies, especially tiny particles that become deeply embedded quickly. The problem is the removal of the bacteria, which naturally calls for a thorough removal of all foreign particles, both large and small. Dead tissue, *if free from bacteria*, will do no harm aside from sloughing out later. In thinking over this problem, I recalled having once cleaned a small, dirty wound by irrigating it using a hypodermic needle and a 50 cc. syringe. The effectiveness of this tiny stream, driven into every crack and crevice of the area under some pressure, in dislodging every tiny particle had been very impressive. It was decided that if by some means one could likewise concentrate a battery of such fine streams, under pressure, in a given area, such an area would be more thoroughly and efficiently cleaned in far less time than by any other known method. A considerable amount of experimentation was carried out, and the following equipment* has proven satisfactory:

1. An ordinary air-duster gun, of the sort used in machine shops, is used, fitted with a special irrigator head (fig. 1).

2. This head is made from a piece of .5 inch brass rod, about 2 inches long, drilled out to within .125 inch of its distal end, which is drilled through with thirty holes made with a No. 73 jeweler's drill. These holes are tiny parallel tubes which direct the streams of water in parallel lines, concentrating all thirty streams in an area not more than .5 inch in diameter (fig. 2).

FIG. 1. Irrigator gun with special head and pressure tubing attaching it to water outlet. The "trigger" on the gun turns the water on and off; the wall valve regulates the amount of pressure.

3. Ordinary pressure tubing connects the irrigator gun to city water. At St. Joseph's Infirmary this water in the emergency room comes through the heater, is warm, and is at about 45 pounds pressure (fig. 1).

4. A drain box, 16 inches square, 4 inches deep, scalloped on each side, with a 1 inch side drain and a removable grill over the top are necessary equipment (fig. 2).

5. A large clear plastic or glass funnel is

*Designed and manufactured by the Corell Co., Houston.

useful to minimize the amount of spray deflected as the irrigator is used (fig. 2).

The pressure is varied according to the type of wound, and one learns to regulate this properly with use. From 35 to 40 pounds is about the maximum, and this is very efficient in cleaning compound injuries. A protruding bone end is more rapidly and efficiently cleaned by this method than by any other.

FIG. 2. Drain box with removable grill and side drain. Note the use of a glass funnel to prevent rebound of water. Note also the intense concentration of thirty fine streams in a small area.

Anesthesia, local, regional, or general, is used. The pressure irrigation is rather painful, but so is almost any method to some extent. Appropriate anesthesia is selected for each case.

Method of Use.—The injured part is placed on the grill, and the surrounding edges and area are thoroughly cleaned with soap and water and shaved. No attempt at this time is made to clean out the wound itself. If local anesthesia is chosen, it is injected to block the skin edges and any nerves within the depths of the wound. After injecting the anesthesia, the shaved area is pressure irrigated, the wound itself is thoroughly pressure irrigated, the edges are painted with a little antiseptic, sterile drapes are laid on the grill and about the now well cleaned wound and surrounding edges, and suturing is done without moving the patient from the grill.

In scalp wounds where the inner table is intact, this procedure not only thoroughly cleanses the wound itself, but will quickly remove all grease, dirt, and blood from the patient's hair, which ordinarily is quite difficult to accomplish.

Wounds of the hands and fingers of working men such as machinists are usually very hard to clean by other methods, but if the injury is reasonably recent it can be readily cleaned by pressure irrigation.

Extensive lacerations full of dirt and grit are readily and thoroughly cleaned in a minimum time. This type of injury has always required a great deal of time, but with this equipment it now requires a rather short length of time.

It is to be emphasized that no soap, scrubbing, or mopping within the wound itself is necessary: the battery of fine streams concentrated in a small area dislodge all foreign particles almost instantly, and scrubbing and mopping are both unnecessary and undesirable. Second, the force of the streams carries these foreign particles on out of the wound, and they are not just washed out of one part of the wound and allowed to settle in another. Third, a maximum amount of cleaning is accomplished in a minimum amount of time, an item of importance. Fourth, while the amount of water used is quite large, it is used with maximum efficiency. At 30 pounds pressure one uses a little less than a gallon a minute, and this gallon is broken up into thirty fine streams all concentrated in a small area.

In using water under pressure in this manner, there is a considerable amount of rebound of the streams. This is readily controlled by holding a 6 inch glass funnel upside down over the area being cleaned (fig. 2).

Again it should be emphasized that this method is not meant to replace debridement as the latter will always be irreplaceable under certain conditions. However, after one has thoroughly pressure-irrigated a wound, the dead tissue appears rather distinctly separated from the living, and I believe that any necessary debridement can then be more accurately done. Pressure irrigation as described herein is an adjunct to the present traumatic surgery armamentarium for cleaning up dirty wounds, but is no complete solution. It has certain advantages that become evident to one who uses it often—like everything else the user must become familiar with his instruments.

In summary, we have used this method at St. Joseph's Infirmary for more than two years in all types of injuries and have found it efficient and satisfactory. It is simple, extremely rapid, thorough, and no ill effects have been attributed to its use. I believe the principle of cleaning traumatic wounds by multiple fine-stream pressure irrigation is a

definite improvement over other existing methods.

1704 Crawford.

MANAGEMENT OF PROSTATIC SURGERY IN THE AGED

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This report presents clinical data on 100 consecutive patients who were operated upon for the treatment of prostatic obstruction. Of the 100 operations, 83 were done by the transurethral route and 17 by the suprapubic route. Of the 83 patients operated on by the transurethral method, 5 had had preliminary cystotomy. Of the 17 suprapubic prostatectomies, 3 had one-stage operative procedure. Nine of the patients had previously been operated upon either by suprapubic prostatectomy or transurethral resection. Five had had previous transurethral resections and 4 had had open operations. The average age was 69.2 years, the oldest patient being 98 years of age. The greatest percentage of the patients operated upon were between the ages of 70 and 80 years. In the total 100 cases, the duration of symptoms was less than one year in 65 and from 1 to 3 years in the remaining group. The preliminary stay in the hospital before the operation was from less than one day to ten days. The postoperative hospitalization was on the average of seven days.

It has been a matter of considerable interest to me to observe the reaction of patients toward submitting to transurethral resection following a previous resection performed by me or elsewhere. In the 5 patients who had previously been operated upon by this method, there was none who expressed a fear of having the operation repeated at this time, whereas the patient who had had a previous open prostatectomy stated that he did not desire to have an operation with an incision but was quite anxious to have the transurethral route employed upon him. Of the 100 patients, 11 had bladder calculi associated with their enlarged prostate. The consensus is that vesical calculus does not constitute a contraindication to the performance of transurethral resection unless the calculi are excessively large size.

The quantity of tissue removed in the transurethral group varied from less than 3 Gm. to more than 75 Gm. Seven of the transurethral group had secondary resections five to eight days following the first operation. If the patient has a large gland and I am unable to take out sufficient tissue in from forty-five minutes to one hour, I think it better to do a second stage resection on him than to take a chance of possible surgical shock, complications, and so forth.

The operative and immediate postoperative mortality constitutes an important dictum in consideration of the merits of any operation. The mortality rate in these 100 consecutive cases was zero. I might add that I have followed these patients since their discharge. There have been 5 deaths in this total group since discharge from the hospital. One patient on whom resection was done five months ago died three weeks later with a carcinoma at the head of the pancreas. Another patient, age 84, died of myocardial failure two months after operation. The third patient died of pneumonia and senility five months after the operation. One patient died from cerebral embolus and cardiovascular renal disease two weeks after he returned to his home. The fifth patient died from coronary occlusion eleven months following operation.

Microscopic and pathological examinations of the tissue removed from the 100 patients revealed carcinomatous tissue in 11, ranging from grade 2 to grade 4. The 11 patients are now receiving stilbesterol, and 3 of this group have had bilateral orchidectomy.

Preoperative management of patients suffering from prostatism varies greatly. The patient's physical and mental condition, complications which have previous occurred, will dictate the procedures to be followed in each case. Generally speaking any patient who is ambulatory and free from such complications as renal insufficiency, cardiac decompensation, or sepsis may be operated upon without any preliminary treatment. But the majority of persons who require endoscopic prostatic surgery are not good risks. Because of their age they are subject to many of the degenerative diseases such as arteriosclerosis with or without hypertension and most of them are potential victims of coronary occlusion or cerebral accidents. Such accidents may occur at any time and any type of disturbance is likely to precipitate them. Especially true in regard to elderly persons is that the more efficiently, easily, and quickly the operation can be done and the smaller amount of anesthetic agent which can be used, the more successful the outcome will be. On admission to the hospital, if the patient does not seem to be an excessively good risk, catheter drainage is instituted and the blood chemistry and cardiovascular system are checked thoroughly. These patients are not advised to stay in bed unless they are desperately ill. It must

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be remembered that the older a person gets the poorer he tolerates bed rest. The patient is told just what his trouble is and the type of obstruction that he has present. The operative procedure is explained to him and he is told what to expect from his operation. Gaining the patient's confidence is of the utmost importance in this age group and he does appreciate an explanation of what it is all about.

I do not believe that cystoscopic examination should be routine procedure for the diagnosis of prostatism as the dangers of instrumentation which result from these procedures may in some instances outweigh any advantages which might be gained from their use. In doubtful cases the examination can be done in the operating room with a clear understanding that if the diagnosis of prostatism is confirmed a resection will be done under the same anesthesia. This procedure eliminates unnecessary examination and lessens the risk of injury to the patient who may have a comparatively feeble myocardium or an infected urine. As stated before, in the uncomplicated cases of prostatism it is better to submit the patient immediately to resection instead of making him undergo the preliminary period of catheterization. Nothing is more discouraging to a person than to have to wear a retention catheter for a considerable length of time. Beside the possibility of causing more infection the patient loses ground both from a mental and physical standpoint.

When the patient is ready for operation, my preoperative orders are 1.5 gr. nembutal the preceding night and 1/3 gr. pantopon and 1/150 gr. atropine the following morning before surgery. One hour following this medication, the patient is carried to surgery. The type of anesthesia is of topmost importance and cannot be stressed too greatly. In my experience the ideal anesthesia for transurethral resection is low spinal and sodium pentothal. The low spinal anesthetic blocks the lower sacral and pudendal plexuses; it produces a complete anesthesia confined to the perineum, the genitalia, and the bladder, and it extends to a point midway between the suprapubic and the umbilicus. It does not often produce motor paralysis of the lower extremities.

The technic of low spinal anesthesia is as follows: A 22 gauge spinal puncture needle with a 45 degree bevel tip is used for making the spinal tap at the level of the third or fourth interspace; a tap at the fifth interspace is made if possible, while the patient is sitting in the upright position. One-half ampule of ephedrine sulfate is given just before the spinal needle enters the canal. After the tap is done, 1 to 2 cc. at most is allowed to drip into an ampule containing 50 to 100 mg. of novocaine crystals. It must be remembered that there are three factors of major importance which regulate the level of anesthesia. First, the level of anesthesia is directly proportional to the volume of spinal fluid; second, the higher the level the larger the dose needed; and third, the greater the speed of injection the higher the immediate level. Therefore, after 2 cc. of spinal fluid is obtained and mixed with 100 mg. of novocaine crystals, from .5 cc. to .75 cc. is slowly injected into the epidural space and the spinal puncture needle withdrawn. After the spinal anesthetic has been given the patient is supported in the sitting position for a period of three minutes while the anesthetic agent becomes fixed to the nervous tissue below the level of the spinal tap. After this period has elapsed, the patient can be placed in the horizontal position and will not develop a higher anesthetic level. Extensive experience has demonstrated its safety. There is virtually no vasomotor collapse.

During the operative procedure it is well to watch the patient closely. If he complains of undue physical distress or mental anxiety an investigation as to the cause should be made immediately. As the anesthetic does not affect the lower extremities and since the patient's legs are held in a fixed and unnatural position for a long period of time, he may be made exceedingly uncomfortable by fatigue and cramping. This might, and can, constitute an additional operative insult that may substantially contribute to the precipitation of surgical shock. Therefore the patient's complaints during the surgery should not be disregarded, and he should be allowed to move his legs and change his position if he is uncomfortable. During the operative procedure I routinely give blood plasma or whole blood. The operation usually takes from twenty to sixty minutes. If I find I am unable to remove sufficient tissue in one hour's time I usually stop and plan to do a secondary resection seven days later. Hemorrhage is poorly tolerated by the aged. Therefore, it is necessary that there be complete hemostatis during all the operative procedure. The time to stop hemorrhage is on the operative table and not in the room one to six hours later. It has been demonstrated recently by clinical observation that sodium chloride or normal saline is poorly tolerated following hemorrhage or burns, whereas sodium lactate or bicarbonate solution or glucose may be administered with relative safety to patients suffering from recent hemorrhage. If fluids

are necessary I routinely use sodium lactate or Hartman's solution. I think parenteral administration of fluids is overdone and often it is this "occasional or extra jug of glucose or saline" that precipitates a chill followed by myocardial embarrassment and possibly death.

After the patient is returned to the room the catheter is irrigated with 1:10,000 silver nitrate. He is instructed to take deep breaths and move his extremities frequently. In this way atelectosis and pulmonary embolism are not encouraged. The following morning he is given a general diet and propped up in bed. He is allowed out of bed on the third postoperative day. The catheter is removed on the third to fourth postoperative day if he has no fever. If he can void without discomfort and has no residual urine, the patient is discharged on the seventh postoperative day. Urethral sounds are then passed every two to three weeks for sixty days and small doses of sulfathiazole are given if needed. It requires approximately six weeks for the excised area to heal.

1442 North Third.

PRIMARY CARCINOMA OF THE GALLBLADDER

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The first note in the literature concerning primary carcinoma of the gallbladder appeared in 1777 in a record by Stoll, of Vienna. The first large series was gathered in 1889 by Musser, who reported 100 cases. The present report includes the clinical and pathological data from 17 primary carcinomas of the gallbladder found at the Scott and White Clinic during 1,600 consecutive operations for diseases of the biliary tract. That this condition deserves repeated investigation is apparent when one considers that a correct preoperative diagnosis was made in this series in only 2 cases.

INCIDENCE

According to Kaufmann carcinoma of the gallbladder forms 5 to 6 per cent of all carcinomas.[3] Among the malignancies of the digestive organs carcinoma of the gallbladder is generally regarded as being preceded in frequency by malignancy of the stomach, colon, and anus.[1] In 1,600 consecutive operations for biliary tract diseases the 17 cases of primary carcinoma of the gallbladder represent an incidence of just over 1 per cent. This is slightly below the average incidence of between 0.5 and 6.5 per cent reported by various other authors.[2, 4, 6, 8] In the present series only those cases on which a definite gross diagnosis of carcinoma of the gallbladder was made at operation (2 cases) and those proven by microscopic study (15 cases) have been included. All cases of carcinoma of the bile ducts were excluded.

As in cancer of other organs the high incidence was in the older age group and ranged from 46 to 68 years with an average of 62 years. Sixteen of these patients were between 55 and 68 years. Ewing[3] reported the average age in his studies to be about 58 years. All patients in this series were white.

Carcinoma of the gallbladder is more common in women than in men. Ewing[3] stated that the ratio is 4 or 5 to 1. In a large series of consecutive autopsies, Van Zandt[10] reported an incidence of 77.7 per cent females. Boyce and McFetridge[1] gave the female incidence as 56 per cent. In this series there were 13 females and 4 males; a ratio of about 3 to 1, or 69.2 per cent.

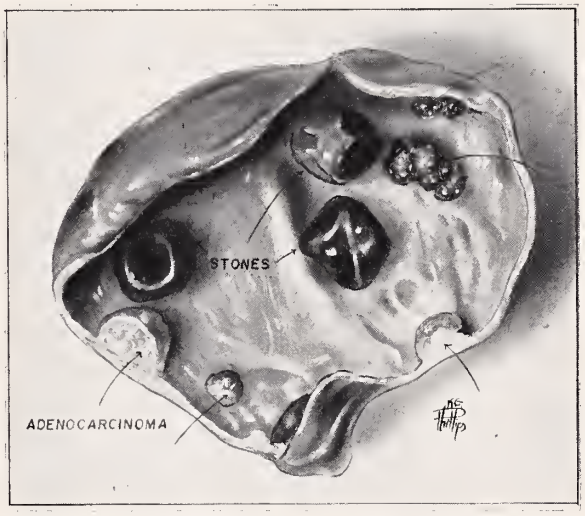

FIG. 1. Drawing of an operative specimen of a case of primary adenocarcinoma of the gallbladder.

STONES

Perhaps the most interesting phase of a study of carcinoma of the gallbladder is its relation to cholelithiasis. Though a causal relationship cannot be conclusively proved because of the difficulty experienced in reproducing the disease in animals, Mallory[7] has stated: "Cancer of the gallbladder, we know, almost invariably occurs in patients who have been chronic carriers of gallstones for ten or twenty years. It is the greatest danger of the so-called 'silent stone' in the gallbladder." According to Ewing[3] "mechanical irritation of calculi, the relation to

From Scott and White Clinic.

a peculiar form of lipoid metabolism (cholesterin), and the irritative and digestive action of bile seem to combine in producing the remarkable susceptibility of this mucous membrane to cancer." In this series 9 gallbladders were opened and all were found to contain gallstones. Only those gallbladders which were actually opened as a surgical or autopsy specimen were included because of the admitted difficulty with which stones may be palpated in a gallbladder infiltrated with carcinoma.

A comparison with other reported series is found in table 1.

TABLE 1.—*Percentage of Carcinomatous Gallbladders Containing Stones.*

	Per Cent
Musser[3]	69
Futterer[3]	70
Zenker[3]	85
Lam[5]	87
Massachusetts General Hospital[3]	88
Zanowski[3]	100
Peco, G., and Cipolla, E.[9]	100
Scott & White Hospital	100

The proportion of cases of cholelithiasis which develop cancer is variously estimated from 4 to 18 per cent.[3] It is obvious then that the mere presence of stones is not the sole etiologic factor. On the other hand, the persistent high incidence of stones in cancer of the gallbladder points to this as a definite contributing factor at least.

PATHOLOGICAL DATA

In the 15 cases available for microscopic study, adenocarcinoma alone occurred in 14 gallbladders. The remaining gallbladder was involved by a combined squamous cell carcinoma and adenocarcinoma.

The factor of visible metastasis was ascertained in 16 cases. The liver had carcinomatous involvement in 62.5 per cent; regional nodes in 19 per cent; ducts in 12.5 per cent; and omentum in 12.5 per cent. In 1 case, with general metastasis, the kidneys, lungs, and pancreas were involved.

Between the gallbladder and the liver the lymphatic system is abundant. In cases of carcinoma of the gallbladder, extension to the liver can occur with relative ease. This accounts for the minimal chances of cure unless the patient is brought to surgery early in the course of the disease. Regional lymph nodes are frequently involved but because of the technical difficulty usually encountered they do not become a surgical problem.

CLINICAL PICTURE

As one might expect in view of the relatively high incidence of calculi and the obstructive nature of the tumor, the history in most of these cases was one of upper abdominal pain (82 per cent), recent gaseous indigestion (53 per cent), chronic gaseous indigestion (47 per cent), loss of weight (45 per cent), awareness of a mass in the abdomen (35 per cent), jaundice (35 per cent), and acholic stools (18 per cent).

As in all reported series, pain is the outstanding complaint. In this series about half the cases gave evidence of previous biliary tract disease, the history of dyspepsia or biliary colic, or both, going back as much as forty-five years. In the other half of these cases, no previous history suggestive of cholecystic disease was elicited and the terminal symptoms had their onset from two to twelve weeks prior to admission.

Reference to table 2 reveals the incidence of the recorded chief complaints at the time of admission.

TABLE 2.—*Incidence of Chief Complaints on Admission.*

Chief Complaint	Incidence (Per Cent)
Pain	71
Mass	24
Jaundice	18
Gaseous indigestion	12
Miscellaneous	29

Four physical findings occurred with the greatest frequency: upper right abdominal tenderness (53 per cent), palpable tumor in the right upper abdomen (47 per cent), jaundice (41 per cent), and liver enlargement (29 per cent).

The following case report is presented because it seems to typify the general observations in a case of carcinoma of the gallbladder from this series.

CASE REPORT

A white woman, age 67, was admitted to the hospital with a chief complaint of weight loss and jaundice. The history revealed that for a ten year period between the ages of 22 and 32 she had had severe recurrent attacks of acute indigestion. The interval history was otherwise noncontributory. The present illness, beginning about three months prior to admission, consisted of slight gaseous indigestion, anorexia, and gradual loss of weight. Five weeks later the weight loss became more rapid. Her physician at that time noted a faint jaundice. In spite of symptomatic treatment, her relatively painless jaundice developed more completely and the patient noticed acholic stools. There had been no vomiting but anorexia had become marked a few days before admission.

Physical examination revealed a markedly jaundiced patient showing the effects of her recent weight loss of 25 pounds in three months. Temperature, pulse, and respiration were normal and blood pressure was 140 systolic, 80 diastolic. The liver edge was felt to be about 4 cm. below the right costal margin. In the right upper quadrant near the midline was a fullness suggestive of a mass. This was not tender to palpation. Urinalysis and serologic studies revealed nothing pertinent. The erythrocyte count was 4,000,000. The leukocyte count numbered 9,650 with a normal differential count. Hemoglobin was 80 per cent and prothrombin time was 55 per cent of normal. The direct Van den Bergh reaction on serum was positive and the quantitative indirect reading was 12.3 mg. per 100

cc. Roentgenograms of the stomach, chest, and colon were negative. The gallbladder film without dye disclosed a large primary gallbladder shadow with small stones. Following adequate preparation for six days the patient came to operation.

The regrettable conditions so often encountered in this type of case were exemplified here. The gallbladder was infiltrated with hard carcinomatous nodules extending into the cystic duct. Several nodules about 1 cm. in diameter were found in the left lobe of the liver. The pancreas was small and soft. A biopsy specimen from the gallbladder, studied by the quick-section method, was reported to be a high grade adenocarcinoma. Additional study after fixation confirmed this report and a microscopic diagnosis of adenocarcinoma of the gallbladder, grade III, completed the report. With the evidence from the quick-section, the condition of the gallbladder and metastasis to the liver, it was decided to limit the operative procedure to this exploration and the abdomen was closed. Convalescence was uneventful though the patient's anorexia and rather marked jaundice continued. She was discharged on the twenty-fourth postoperative day to the care of her family physician. Follow-up revealed that the patient died ten days after leaving the hospital.

LABORATORY DATA

It is generally agreed that the roentgenogram offers little assistance in the diagnosis of malignancy of the gallbladder although benign tumors are reported with some degree of accuracy. The roentgen diagnoses in this series are tabulated in table 3.

TABLE 3.—*Roentgen Studies.*

Type of Roentgenogram	Total Number of Cases	Diagnosis	Number of Cases
Gallbladder visualization	5	Nonfunctioning gallbladder	5
Flat plate	10	Upper right side soft tissue mass	4
		Negative	4
		Probable stones in gallbladder	2

Clinical laboratory findings were not constant nor did they reveal any specific information which might lead to a correct diagnosis.

DIAGNOSIS AND OPERATIVE PROCEDURE

In 2 cases a diagnosis of carcinoma of the gallbladder was made preoperatively. Diagnoses, in order of relative frequency, included cholecystitis with cholelithiasis, cholecystitis, upper right abdominal carcinoma, carcinoma of the pancreas, carcinoma of the gallbladder, right kidney tumor, carcinoma of the cecum, and hydrops of the gallbladder.

Unless the possibility of carcinoma is kept in mind in biliary tract disease, it is apparent that the diagnosis will rarely be made. This is regrettable as the only hope for cure lies in very early diagnosis. That this is true is exemplified in this series, for in 7 patients exploratory laparotomy was the limit of surgical intervention. Two patients received cholecystostomy while 2 died before operation could be attempted. In 1 patient cholecystogastrostomy was performed because of extension into the common duct. In 5 patients cholecystectomy was possible. A drawing of a specimen from 1 of these cases is shown.

SUMMARY

1. Seventeen cases of primary carcinoma of the gallbladder found during 1,600 consecutive operations for diseases of the biliary tract are presented. This represents an incidence of about 1 per cent.

2. The average age is 62 years. The ratio of males to females is about 1 to 3.

3. Of the gallbladders actually opened, 100 per cent contained one or more stones.

4. Pathologic study revealed that all were adenocarcinomata.

5. The liver and regional nodes are most frequently involved.

6. The onset is insidious, but pain, jaundice, gaseous indigestion, and loss of weight are relatively constant symptoms.

7. The prognosis in carcinoma of the gallbladder is poor and hope for cure lies in early operation.

8. A typical case is reported.

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NEW DERMATOLOGY AND SYPHILOLOGY JOURNAL

The publication of a new journal, the *Quarterly Review of Dermatology and Syphilology*, has been announced by the Washington Institute of Medicine, Washington, D. C. This new publication is the tenth in the Washington Institute's group of quarterly reviews covering specialized fields of practice. It will survey all published material on dermatology and syphilology appearing anywhere in the world from January 1, 1946, onward, and will be the first review journal in its field to provide this complete coverage.

Donald M. Pillsbury, M. D., will be editor-in-chief, with Herman Beerman, M. D., and Clarence S. Livingood, M. D., as associate editors. The editorial board includes more than thirty specialists from universities and medical centers throughout the world, and additional acceptance to invitations for membership on the board, principally from other countries, are expected.

FUNGUS INFECTIONS OF THE CORNEA

CASE REPORT OF KERATOMYCOSIS DUE TO MONILIA

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Keratomycosis due to the mold Aspergillus fumigatus was first described by Leber in 1879. This case concerned a farmer who sustained an injury to his eye from the husk of an oat grain. The second case was reported by Berliner (1882) and later was described more fully by Uhthoff. A 23 year old farmer's eye was injured by a falling pear, followed by a very chronic ulcerative keratitis. In both cases it seemed apparent that the foreign body producing the injury had also carried the fungus. Fuchs[11] reported a case in a miller who had returned to his work before a herpes corneae febrilis had completely healed. Presumably the fungus was carried to the affected eye by grain dust, which filled the surrounding air. Other cases followed by Uhthoff and Axenfeld (1896-97), Schirmer (1896), Nobbe (1898), Wicherkiewicz (1900), Markow (1900), Kayser (1903), Buchanan (1903), Johnson (1903), Marlin (1905), Zade (1907), Hayano (1910), Orlow (1913), Lindner (1913), Gruter (1914), Castroviejo and Urra,[5] Fede (1930), and others.

A mycotic infection of the cornea is rarely seen, especially in cold climates. Kanerva[15] reported a case of keratitis Aspergillina and stated that it was the only one which had been described up to that date in Scandinavian countries. It is of interest that most of the cases reported give a history of trauma by some vegetable or earthy material, the foreign body presumably carrying the fungus. On the other hand, Fazakas found fungi in 25.65 per cent of normal eyes and 37 per cent in diseased eyes, which makes one think of the possibility of a secondary mycotic invasion following trauma to the corneal tissue.

After injury by the foreign body, a gray cloudiness appears with a dull, dry crumbling surface, around which develops a sharply defined line of demarkation usually yellowish in color. This line deepens very slowly into a gutter. Finally the slough is cast off, leaving an infiltrated ulcer. The active stage may be associated with iritis and hypopyon (Duke-Elder[7]). Perforation is very rare but can occur (Castroviejo and Urra[5]). The ulcerative process is very slow and chronic. The pain may be slight or very intense. If the lesion is situated near the limbus, the lesion may take on a less serious form and may resemble a fascicular keratitis when vascularization sets in. A microscopic examination of the slough will show a rich permeation of the mycelium which forms a network of fibers. Schirmer (1896) and others have examined whole eyes and found the area of the cornea around the slough densely infiltrated with a ring of leukocytes, while the iris and ciliary body were infiltrated with round cells. Very rarely does the fungus penetrate the inner eye and invade the vitreous.

The treatment recommended is the removal of the slough and cauterizing the site with galvano cautery. The Italian authors recommend large doses of potassium iodide

FIG. 1. Case of keratomycosis (Monilia albicans). Retouched photograph showing appearance of ulcer three days after initial trauma.

in addition to local treatment. A dense leukoma is generally the result if cautery is used. Surgical methods such as paracentesis of the cornea and delimiting keratotomy are not advised. Wurdemann[20] advises that in grave cases with hypopyon, one must abstain from all hasty intervention, as corneal section or the cautery, which may entail irreparable lesions, while the regressive phase of the process may speedily come about and end in cure with comparatively slight changes in the cornea.

Another very rare fungus infection of the cornea is caused by streptothrix actinomycosis. The lesion produced is similar to that caused by the Aspergillus. Cases have been reported by de Bernardinis (1904), Lowenstein (1910-14), Calderaro (1913), Davids (1921), and Zurnedden (1907). Other rare infections caused by fungi have been reported: Cavara[6] described a case of keratitis caused by the mold Mucor; a case of botryomycosis of the cornea reported by Bargeton (1905); cases of Glenospora graphii by

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AUTHOR'S NOTE.—A bibliography of 104 references pertaining to fungus infections of the cornea has been compiled and on request will be made available to any library or researcher in this field.

Morax (1910); Vuillemin (1912); and Wright (1929). The lesion is an indolent ulcer with a dry necrotic base, a sharp gutter of demarkation, and a hypopyon. Fazakas[10] described an interesting case caused by Periconia.

Yeast infestions are exceedingly rare. Stoewer[19] and Lundsgaard[17] reported a very chronic ulcerative hypopyon keratitis due to yeast. Stoewer reported 2 cases of corneal ulcer from which pure cultures of yeast (Rosahefe) were recovered. One case was that of a 45 year old miner, the other of a 52 year old married woman. Lundsgaard's case concerned a 35 year old wooden shoemaker. Pure cultures of yeast were obtained from a very stubborn ulcer of the cornea. Although yeasts are the most widespread of

FIG. 2. Retouched photograph showing extent of ulceration and resultant nebulous scar two months after initial onset of keratomycosis (Monilia albicans).

fungi, being common in the soil and atmosphere, the eye is rarely the seat of any lesion caused by them. Blastomycosis (Monilia) of the conjunctiva is very rare and is generally secondary to infections of the skin of the face and lids and of the lungs (McKee[18]). Busse[4] reported finding Monilia in a corneal ulcer. Dr. D. A. Todd, pathologist with the Nix Hospital Clinical Laboratory, San Antonio, in a personal communication, reported having accidentally recovered a Monilia albicans from a lesion located in the cornea near the limbus. This ocular lesion was found in a U. S. Army nurse on duty in a Belgium hospital in 1944. It is possible for small mycotic lesions of the cornea to heal spontaneously without the true nature of the causative agent ever being suspected, hence the value of bacteriological examinations in all cases of ulcerative keratitis.

The local treatment should be mild; galvano cautery, drastic surgery, and deeply penetrating caustics should be avoided, for the resultant scarring will be unnecessarily dense and resultant complications may be serious. Large doses of potassium iodide are as efficacious in yeast infections of the cornea as in similar infections in other parts of the body.

CASE REPORT

C. V. B., a white man, age 31, felt something hit his left eye while he was riding in an automobile. Three days later he sought medical aid because of severe ocular pain.

He was first seen April 12, 1939. The left eyeball appeared very red from a marked ciliary and conjunctival injection. A linear dendritic type of ulcer was observed running vertically through the center of the cornea, extending 3 mm. from the limbus at 1 o'clock to 4 mm. from the limbus at 4 o'clock. The ulcer was irregularly scalloped along the edges and was not more than 2 mm. wide. The pupil was contracted and the iris markings appeared slightly blurred. A bio-microscopic examination did not show the presence of any foreign body, but revealed that the ulcer was shallow, the edges being slightly undermined with a narrow edge of corneal infiltration. The floor appeared shallow and seemed to be covered with a thin, grayish, dry membrane, firmly adherent to the underlying corneal tissue. There was some increase of corpuscles in the aqueous humor but no hypopyon was evident.

The vision of the right eye was 20/20, while that of the affected eye was 20/50. Wassermann and Kahn tests were negative. Early laboratory examinations revealed scanty growths of a staphylococcus hemolyticus.

There was no history of malaria nor was there any past history having any bearing upon the ocular condition.

The ulcer was first treated by the local application of absolute alcohol; then a few days later by pasteurization. Atropine and dionin were prescribed, and butyn ointment was used for the pain, which was excessive. Sulfanilamide was administered internally, 60 gr. per day for four days. The ulcer was stained with mercurochrome and ultraviolet radiation via a quartz rod was applied locally every five days. The ulcerative process became more extensive. The patient was hospitalized and given typhoid vaccine intravenously while a bacteriophage solution was instilled into the conjunctival sac daily. On May 4, scrapings were taken from the ulcer and sent to the laboratory for further study. The ulcerative process had by this time extended almost to the limbus on the temporal side, pain and tearing being severe and persistent. Treatment by swabbing the ulcer with tincture of iodine, as suggested by consultants, was also ineffective. On May 16, Dr. D. A. Todd reported finding a Monilia albicans growing on Sabouraud's media. With the exception of atropine and dionin, all local medication was stopped and large doses of a saturated solution of potassium iodide (90 drops daily) were administered. Within a week the pain had subsided, and in two weeks all acute inflammatory symptoms had disappeared. The resultant scarring of the cornea was limited to the upper layers. Bowman's membrane was broken through in many places but the invasion of corneal tissue was not profound. Hypopyon was never evident. The extensive lesion involving nearly one-half of the cornea was not completely cicatrized until July, 1939. The final vision was 20/40 not corrected by lenses.

A diagnosis of Monilia albicans infection involving a dendritic type of corneal ulcer, probably traumatic in origin, was based on: (1) the clinical appearance; (2) the stubborn, chronic, progressive course in spite of persistent treatment usually effective in corneal ulcers; (3) the laboratory report of Monilia albicans obtained from corneal scrapings; and (4) the immediate beneficial effects of the in-

ternal administration of potassium iodide in large doses.

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EFFECTS OF EXTREME COLD

Extreme or prolonged cold tends to clot red blood cells so that they plug the circulation, eventually resulting in development of gangrene and loss of limbs. This fact has been established, according to the Surgeon General's office, by study of pathologic tissue from overseas soldiers and experiments with rabbits in which limbs were subjected to temperatures of minus 30 C.

The condition became of great importance in the European theater during the last war. Air crews subjected to extreme temperatures four or five miles over the clouds found that exposure of even a minute or so might result in the loss of a finger. Infantrymen who stayed days at a time in foxholes filled with slush and icy water suffered unbearable pain and inability to walk when relieved from duty, and persistence of the disability and loss of toes were not infrequent.

Major Nathan B. Friedman, of the Army Institute of Pathology, has recently reported on the samples of pathologic tissue. Several varying effects of cold were noted, but in all cases were found the red blood cell plugs which had stopped circulation. The rabbit experiments by Dr. Hurt Lange and David Weiner, of the New York Medical College, working with the Institute of Pathology, revealed the same results. The clotting could be prevented in the rabbits, however, by injections of heparin. Treated rabbits seemed little worse off when their legs were thawed.—S. G. O. Notes, July 31, 1946.

AN EPIDEMIOLOGICAL INVESTIGATION OF TYPHUS FEVER IN TEXAS, 1943-1945

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Typhus is a problem primarily of the southern United States although cases are occasionally recognized far to the north. In 1945, the 1,833 cases of typhus fever reported in Texas accounted for more than one-third of the 5,167 cases reported throughout the United States. Many cases are undiagnosed or unreported and it is conservative to estimate that 3,000 cases of typhus actually occurred, rather than the 1,833 cases which were reported in 1945.

Distribution of typhus cases reported, 1941-1945, in Texas is shown on figure 1. The comparative incidence in relation to recent yearly totals for the entire United States is shown in table 1.

While, according to Bohls,[1] typhus was first recognized in the middle and lower Rio Grande area, the disease has been reported with increasing frequency over much of the state. In 1927, only 25 cases were reported, but in 1934, 465 cases were reported. In 1942, 1,204 cases were reported and 60 deaths were charged to typhus. Of the 254 counties in Texas 180 had reported typhus by 1946. The remaining counties are mostly in west Texas where the population is scattered or reporting of communicable diseases is unsatisfactory.

While typhus is endemic in nearly every sector of Texas, cases tend to be sporadic and sometimes the infection appears to remain dormant for years, as suggested by figure 2. Most cases occur in the summer months and a peak is usually reached in July or August, as shown in figure 3.

TABLE 1.—*Comparative Incidence of Typhus In Texas and the United States.*

Year	Texas Totals	United States Totals
1942	1,204	3,720
1943	1,452	4,533
1944	1,740	5,352
1945	1,833	5,180
1946, First Quarter	202	576

Males are infected slightly more often than females, as shown in table 2. It is noticeable that typhus appears to be less common in Negroes.

TABLE 2.—*Distribution of 525 Cases of Typhus by Sex and Color, 1943-1945.*

MALES			FEMALES		
White	Negro	Total	White	Negro	Total
286	16	302	212	11	223

*Associate Director of Laboratories and State Health Officer, respectively, Texas State Department of Health.

Read before the Section on Public Health, State Medical Association of Texas, Annual Session, Galveston, May 8, 1946.

All ages are susceptible but the disease is at least less commonly recognized in children. The distribution of cases by age group is shown in table 3.

TABLE 3.—*Distribution of 503 Cases by Age Group, 1943-1945.*

Age Group	No. Cases
0-10	25
11-20	94
21-30	83
31-40	96
41-50	100
51-60	47
Above 60	58

The severity of infection shows considerable variation. While death from typhus is uncommon, the illness frequently is severe, particularly with old persons among whom death most often occurs. The onset usually is rather sudden and in many instances the illness is ushered in with chills. The patient nearly always complains of headaches and other body pains. Constant fever usually persists about two weeks. The temperature peaks are variable but tend to reach or exceed 103 F., and peaks of 104 F. or more are not uncommon. The rash is macular in character and appears first on the chest, back, or abdomen, in most instances four or five days after onset. Later the extremities may become involved. The spots tend to be evanescent and often are not observed.

Laboratory aids are of great value in the diagnosis of typhus fever. While the serum agglutination test, frequently known as the Weil-Felix test, with patient's serum has long been known to be of great value, the complement-fixation test employing the patient's serum is even more reliable and also permits differentiation of typhus and spotted fever. Unfortunately, the titers with either test are unlikely to reach high levels before the beginning of the second week of illness and repetition of the test is frequently necessary in order to detect significant titer changes.

In searching for a source of infection, results of laboratory tests on rats or their fleas taken at the patient's home or place of work have proved very helpful. It is not at all unusual to find the focus of infection for several cases to be a feed store, grocery store, meat market, barn, or a rat-infested residence. Other foci may be present.

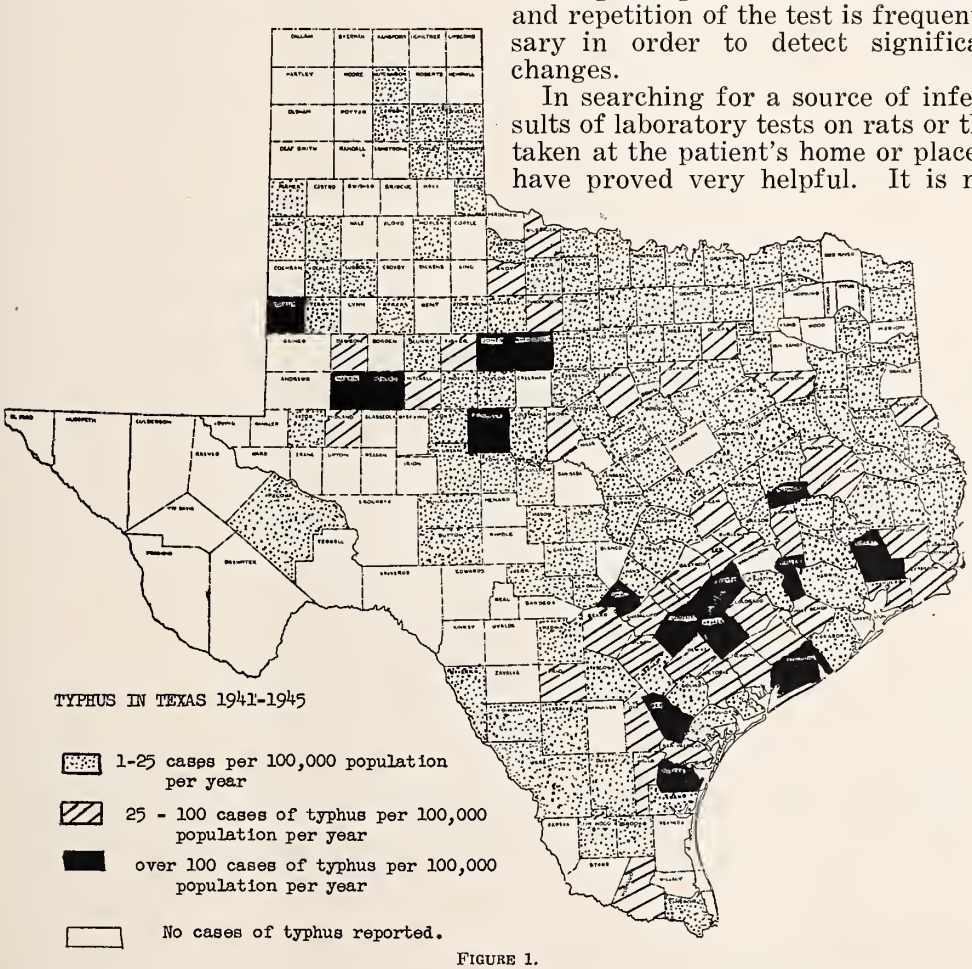

FIGURE 1.

The results of a rat serological survey at Austin in 1945 are given in table 4.

The tropical rat flea appears to play the major role in transmission of typhus from rat to rat or from rat to man, but other fleas

and perhaps rat lice or other ectoparasites play a part. The results of typhus tests on rat ectoparasites taken at Austin in 1945 are shown in table 5. It should be noted that

TABLE 4.—*Places Surveyed for Typhus at Austin, Texas, in 1945.*

Number places sampled	23
Number places positive	18
Per cent positive	75%
Number rats tested	68
Number rats positive	26
Per cent positive	38%

this tabulation shows all pools of lice negative for typhus; however, in tests elsewhere evidenee of typhus in rat lice has been found.

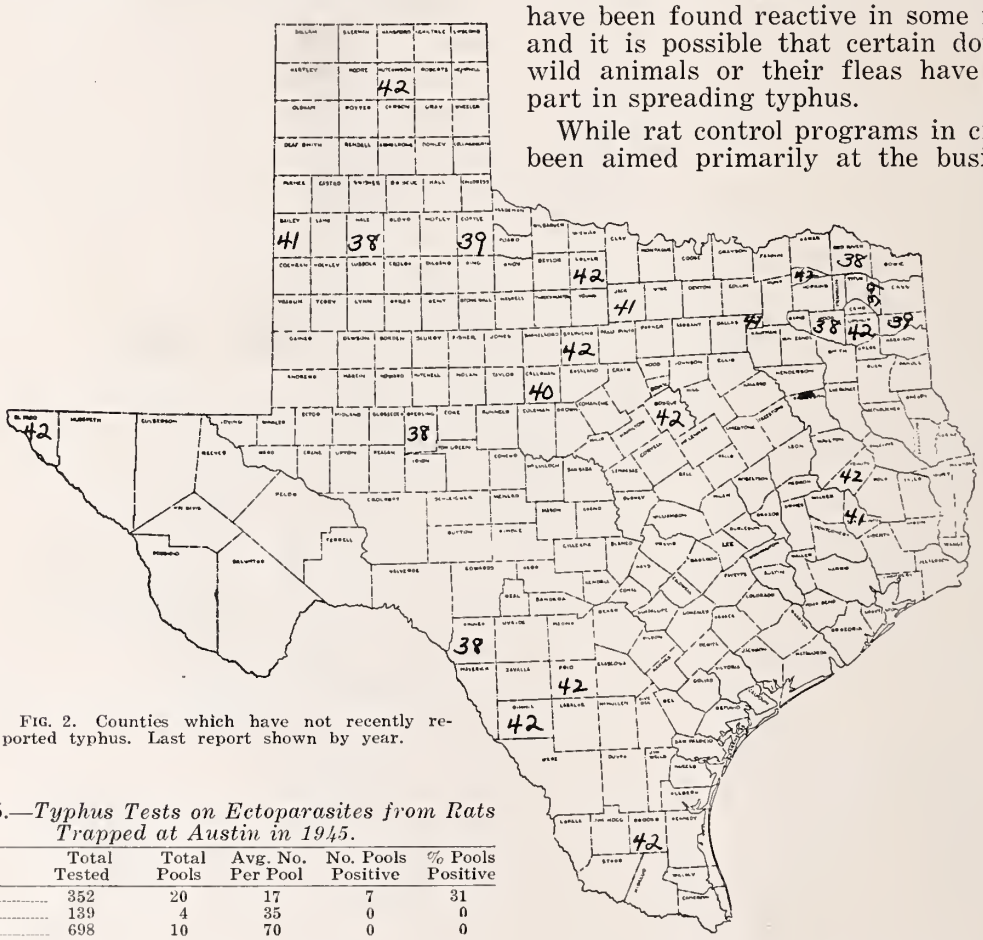

FIG. 2. Counties which have not recently reported typhus. Last report shown by year.

TABLE 5.—*Typhus Tests on Ectoparasites from Rats Trapped at Austin in 1945.*

	Total Tested	Total Pools	Avg. No. Per Pool	No. Pools Positive	% Pools Positive
Fleas	352	20	17	7	31
Lice	139	4	35	0	0
Mites	698	10	70	0	0

Surveys of murine typhus based on laboratory tests of rat blood or rat fleas in several communities in Texas, as conducted by the Texas State Health Department, suggest in many localities that the majority of adult rats have been or still are infected. This is brought out in table 6, which summarizes results with complement-fixation tests on rat bloods in several Texas towns and cities.

During the past year typhus in house mice has been found repeatedly. However, blood

TABLE 6.—*Results of Blood Tests on Rats in Texas in 1945.*

Area of State	No. Tested	Total No. Positive	% Positive
South Texas	135	89	65
Southeast Texas	184	105	57
Southwest Texas	33	19	57
East Texas	41	14	34
Central Texas	107	54	50
West Texas	11	4	36
Total	511	285	55

tests on mice have given a definitely lower ratio of positive reactors than with rats.

Fleas carrying typhus have been found on opossums and puppies,[6] and again on kittens as previously reported.[5] Blood tests on certain animals in addition to rats and mice have been found reactive in some instances, and it is possible that certain domestic or wild animals or their fleas have a minor part in spreading typhus.

While rat control programs in cities have been aimed primarily at the business districts, there is growing evidence of the importance of typhus in residential areas. Bowman[2] has reported that while the rat stoppage program in the Corpus Christi business district was considered a success, nevertheless this did not suffice to control typhus in the city. A good proportion of cases in Austin and San Antonio in recent years have also been traced to residential areas. Attention also has been called to the prevalence of typhus on the farms in many south Texas

communities. It seems evident enough that more attention must be given to control of typhus in residential areas of cities as well as in the business districts, and also on the farms.

Davis[3] has reported that DDT dusting of rat runs is effective in lowering the rat flea index. Based on the report by Davis[3] and reports[9] of results of research particularly in Lavaca County, the Texas State Health Department is employing DDT dusting of rat runs followed by poisoning, particularly with 1080, for typhus control. The economic losses charged to rats and hazard from plague and other rat-borne diseases necessitate long range plans to hold rats and their fleas at a minimum.

Observations on the possible value of typhus vaccination are of great interest. The State Health Department in its Hallettsville project in Lavaca County at the present time

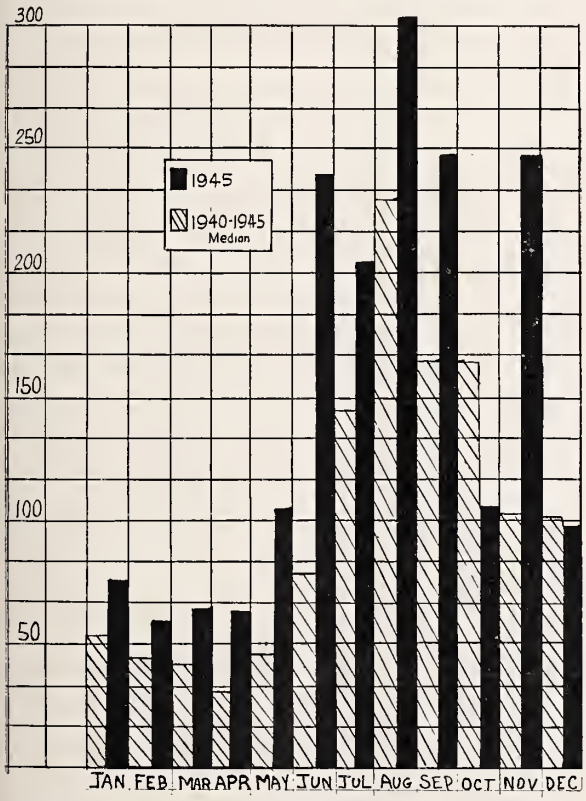

FIG. 3. Monthly incidence of typhus fever in Texas.

is attempting to evaluate vaccination as a control procedure.[9] The State Health Department is indebted to both Dr. H. R. Cox, Director of Virus Research, Lederle Laboratories, and Dr. M. Ruiz Castaneda, Typhus Research Laboratory, Hospital Generale, Mexico City, for grants of liberal quantities of typhus vaccine for field and laboratory investigations. Other than that these vaccines stimulate the rapid appearance of complement-fixing antibodies, no conclusive statement regarding immunizing capacity for man is warranted; however, the work has been going long enough with the Cox-type vaccine to suggest that this vaccine is of protective value. Both the Cox- and Castaneda-type vaccines give considerable protection experimentally for laboratory animals and should be of value for human protection.

DISCUSSION

The public health importance of typhus in Texas is evident when one realizes what a big fraction of the total number of cases reported in the United States the Texas cases represent. There can scarcely be any doubt that the apparent spread of typhus fever in Texas in recent years is real. However, better recognition and reporting of the disease has unquestionably accounted for some of the apparent increase in prevalence. Increased attention to laboratory confirmation by means of the Weil-Felix test and, more recently, the complement-fixation test has been helpful to many physicians in making sure of the diagnosis.

Both Meleney[7] and Topping and Dyer[10] have commented on the apparent recent extension of typhus in the United States. The role of rats and their fleas as the fundamental source of infection is well established, through the work of Mooser, Castaneda, and Zinsser[8] and Dyer, Rumreich, and Badger.[4] Our[5, 6] findings of infected fleas on kittens and opossums suggests that perhaps other ectoparasites or other animals may have at least a minor role at times in the economy of typhus rickettsiae.

Since typhus preëminently is a disease associated with the rat and its fleas, it is evident that control measures should be directed against the rat and its fleas. In areas where rat control cannot be accomplished it is possible that vaccination would be useful, if it should be shown conclusively that vaccination is effective in reducing both severity of infection and actual typhus morbidity.

SUMMARY

In 1945, the 1,833 cases of typhus fever reported in Texas accounted for more than one-third of all such cases reported in the United States.

This disease either has been spreading rapidly or has been increasingly recognized in Texas.

Recent surveys have indicated that a high percentage of rats in many Texas communities have harbored this infection.

Poisoning of rats with 1080 after dusting

of rat-runs with DDT is a relatively new but promising control procedure.

Typhus vaccination is also a promising control procedure.

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TEAMWORK IN CANCER CONTROL

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Cancer can neither be diagnosed nor treated successfully without coöperative effort. Probably no other disease requires so much coöperation from so many people and from such a variety of people as does this number two cause of death.

The commonly accepted dictum "no cancer diagnosis is complete without pathologic confirmation" immediately establishes the idea of the "team" in diagnosis. The patient usually is first seen by the family physician, a general practitioner. If cancer is suspected, help must be sought from one or more of the specialist group. The general surgeon or the surgeon in some special field, the roentgenologist, and finally the pathologist and his technician, all are called upon to play a part. This teamwork becomes increasingly important as the educational efforts of the official and voluntary health agencies succeed in bringing to the physician's office an increasing percentage of curable cancers. Cancer which can be diagnosed merely by the history or by a simple examination is seldom curable cancer; the diagnosis of early cancer requires teamwork.

This observation is equally true in the case of cancer therapy: the surgeon and the radiologist must help the internist. More than that, cancer surgery is more and more becoming radical surgery and there is a growing tendency for cancer specialism even within the fields of the several surgical branches. It is a growing recognition of these facts which is resulting in the creation of special cancer services in general hospitals and in the establishment of special cancer hospitals.

The need for this clinical teamwork is well known to all physicians; it is mentioned at this time merely to lend emphasis to two points: first, that there is another member of this clinical team whose importance is sometimes overlooked, and second, that the clinical team is not the only team needed in cancer control.

The overlooked member of the clinical team is the patient himself. Regardless of the excellence of the diagnostic and treatment skills and facilities available in any community, with the sum of our present knowledge no one can hope to cure patients suffering from advanced, disseminated, generalized cancer. Cancer to be curable must be localized cancer; localized cancer is usually early cancer; seldom does the physician see early cancer unless it is brought to him by the patient himself; and the patient cannot be expected to seek help for early cancer unless that patient has been instructed, unless he knows what to look for, what to be suspicious of, and what he can hope for if he reports promptly to his physician for medical advice.

There is occasional criticism that public education on the subject of cancer is producing cancer fear or "cancer phobia." Truly has it been said that fear does not metastasize. It is easier to cure people of their fears than to cure them of advanced cancer. Blind, unreasoning fear is usually the product of ignorance. Man's greatest fear is the fear of the unknown. Once we have the facts before us in any situation, our fears usually give way to action. Once we understand what is needed we can formulate plans of action and our terrors are replaced by determination. So with cancer. The patient with an unreasonable fear of cancer is the patient whose knowledge of the subject is limited. What is needed for that person is more education, not less.

The objective of public education in cancer control should be to remove from each person the ignorant fear which prevents him from taking steps to promote his own safety, or the equally dangerous ignorance which creates a feeling of indifference and a failure to recognize the presence of danger. For ignorance must be substituted a combination of intelligent concern and reasonable optimism. People must be taught to be concerned over the presence of a symptom which might indicate cancer; they must be taught to real-

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ize that in prompt action lies their only hope of safety; but they must also be taught that in many types of cancer this prompt action can bring them a reasonable hope for prolongation of life or of complete freedom from the disease.

So, to the clinical team must be added the other important member: the informed and coöperative patient, the patient who will permit the other members of the team to make use of their knowledge and their special skills at a time when there is some chance that they can effect a cure. Doctors cannot go out and drag into their offices cancer patients they may chance to find walking along the street. Neither can the person with early cancer be expected to report to his physician unless someone has taken the trouble to tell him where he fits into this important team and what is expected of him in his own behalf.

Who is going to instruct that patient, and how is it to be done? This introduces a consideration of the other team which must be created if there is to be success in treating cancer as a problem of community health and welfare as there is beginning to be success in treating individual cases of the disease.

Obviously the first member of the team is the physician himself. As the others of the team increase their efforts to bring cancer education to the general public, the physician will be called upon more and more for advice and for information. He will be asked, first of all, whether he approves of the program and whether he believes that the information being distributed is correct; perhaps he will be asked whether the program should be supported. Here we hope he will remember that he is himself a part of the team and that the rest of the team needs his support.

Soon the physician will notice an increasing number of his patients coming to him for professional advice. They will want to make certain that they do not have cancer. Some of them will be suffering from this disease. Early cancer is difficult to detect and nearly impossible to diagnose without consultation at least with the pathologist. The physician should demand a complete and adequate explanation for any obscure symptom. It might be cancer. Someone has said that the greatest and most important discovery in the entire field of medicine is the discovery that one should take nothing for granted. This discovery is particularly important in cancer: if you don't know, find out.

More frequently a less serious explanation will be found for the patient's complaints. In this event the educational effort has again served a good purpose: "early diagnosis and prompt treatment" is a good motto for diseases and conditions other than cancer and the physician again has an opportunity to be of service to his patient.

But what of those patients whose complaints are vague and trivial, or who present themselves for examination without specific complaints? Here the physician should exercise the highest degree of patience and good judgment. These persons are entitled to a sympathetic hearing and a careful examination. The physician should remember that the symptoms of early cancer are at best vague and confusing, and that they are particularly so to the patient. The public is being asked to seek an explanation for "danger signals" which might mean cancer. Perhaps one measure of the success of this educational effort will be the number of patients coming to the physician either without symptoms or with inconsequential symptoms. The physician should remember that unless cancer can be diagnosed while it is still in that state of vague indefiniteness, the patient's chances for ultimate cure are slim.

The physician should find time to talk with such patients, to encourage them to report regularly for physical examination and immediately at the first sign of trouble. Finally, the physician should find time to give these patients a careful and adequate examination backed by a complete and searching history. No such examination is complete without careful attention to the pelvis. A rectal examination should always be done; in the male this should include careful palpation of the prostate. In the female there should be a careful vaginal examination including a visualization of the cervix with the help of a speculum and a good light. Thoroughness of this type should apply to the other regions of the body, including those areas where lymph node enlargement is most frequent.

Thus the physician becomes the first and most important member of the team. Who else is needed?

Immediately there comes the need for the physician's professional organization, his state medical association and his county medical society. This new community team is going to require constant professional advice and guidance in the preparation of educational material and in the conduct of its program. This help can best be given through an appropriate committee of the local medical group. The cancer committee of the State Medical Association of Texas has always been the most important factor in the cancer work in this state. We hope that there will be a similar committee in every

county medical society. As the rest of the team is formed and starts to function, these county society committees will become of increasing importance. It is particularly important that this group be ready to supervise any activity which involves direct contact with the cancer patient.

Who else? Well, there are two groups who have an official and legal responsibility in any cancer control activities. They are the official health and welfare organizations. The members of these two groups thus become members of the community team who have a most important part to play. Unofficial health and welfare agencies have an equally logical interest in a community program of cancer control and must be made part of the team. The dentist has an unmatched opportunity to detect early cancers among his patients, thus the dentist too belongs on the team. In all parts of the country, the cancer education program is being accepted as a part of the community responsibility of the public schools; thus we need the help of the professional educators.

Perhaps it would be best to say that every person in the community who has an interest in the health and welfare of himself or of his neighbor should be enrolled in this effort to control America's number one enemy. And that is precisely the program of the American Cancer Society and the plan of the Texas Division of that society, now being formed.

Following the pattern of the councilor districts of the State Medical Association it is planned to create in each district a group of workers—a team—which will have three major sources of strength and leadership. First will be the medical profession who will be looked to for advice and guidance on all phases of the program and who will be entrusted with the control of all activities of a strictly medical nature. Second will be the civic-minded leaders of women in the community who will recruit a field army of workers to carry the cancer message eventually into every home in the state and who will render voluntary service to the cancer patients either confined to the home or under treatment in the hospital. These workers will be under the constant supervision of the medical members of the group and can be depended upon to render valuable service to their community. The final source of strength and leadership will be sought from the business men of the community whose primary responsibility will be to secure the funds necessary for the furtherance of the program and also to provide continuous supervision over those funds to make certain that they are wisely administered and economically expended.

The program of the American Cancer Society has three main divisions: research, education, and service. The research program is being coördinated on a national basis through a special committee, known as the Committee on Growth, of the National Research Council, an agency of the National Academy of Sciences. Allocation of funds for research purposes is made only upon the recommendation of the Research Council, which invites application for grants from competent research groups in Texas or elsewhere.

Sixty per cent of the money collected in the annual campaign for funds remains in the state where it is collected. It is to be spent for programs of education and service. The Texas Division is seeking the help of the State Medical Association, the medical schools, the official agencies, as well as of the local physicians to make certain that these programs are wisely planned and carefully administered. It is expected that funds will be made available for statewide projects of an educational nature, including the creation of opportunities for postgraduate study by physicians and similar opportunities for the other professions involved in cancer control activities. It is the ambition of the Division to reach every person in Texas with the message that many cancer deaths could be prevented by prompt recognition of the danger signals followed by early and adequate treatment.

As funds become available, it is hoped to assist in the provision of service to the cancer patients of the state. This service will consist not merely of those personal services which can be rendered by well-trained volunteers, but also services of a strictly professional nature including the detection, diagnosis, and treatment of cancer, and the care of the cancer patient, including the advanced case. This part of the program will be undertaken only with the strictest medical supervision. No such activity will be undertaken unless it conforms to general principles approved by the State Medical Association and unless it shall have the prior approval of the county medical society directly concerned. The Division will not be permitted by its by-laws or its charter to own or operate any hospital, clinic, laboratory, nursing home, or other physical facility, but it will assist existing approved institutions through the provision of funds or voluntary services. It will also be considered appropriate to assist the local medical profession to secure additional service facilities if such be necessary.

This is the organization now being formed in Texas. It has been referred to as a team, but it will not be playing a trivial game. Rather it will be engaged in a grim battle against a powerful adversary. The clinical team fights against an insidious, treacherous, and relentless disease. Our community team faces this same enemy, but also must face its allies: ignorance, fear, superstition, and social taboo.

The people of the state are contributing of their funds to fight this disease. We who are organizing this new division of the American Cancer Society are merely attempting to mobilize the forces of the community to make certain that these contributed funds are wisely and effectively utilized. In the plan of organization are provided complete medical control of all medical activities and complete medical supervision of the entire program.

It is my pleasure at this time to offer to the physicians of this state, through their recognized and official organization, the financial resources, the experience, and the sincere, altruistic interest of this newly-formed health agency. We want to help you doctors fight cancer as a community problem and thus make it easier for you to handle it when it is presented to you as a medical problem.

2310 Baldwin St.

MISCELLANEOUS

COMING MEETINGS AND CLINICS

State Medical Association of Texas, Dallas, May 5-8, 1947. Dr. C. C. Cody, Jr., Houston, President; Dr. Holman Taylor, 1404 W. El Paso St., Fort Worth 3, Seeretary.

American Medical Association, House of Delegates, Chicago, December 9-11, 1946; Regular General Session, Atlantic City,. N. J., June 9-13, 1947. Dr. Harrison H. Shoulders, Nashville, Tenn., President; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secretary.

Southern Medical Association, Miami, Fla., November 4-7, 1946. Dr. M. Y. Dabney, Birmingham, Ala., President; C. P. Loranz, Empire Building, Birmingham, Ala., Secretary-Manager.

Southwest Allergy Forum, Shreveport, La., March 31-April 1, 1947. Dr. W. H. Browning, Shreveport, La., President; Dr. Sim Hulsey, Medical Arts Bldg., Fort Worth, Secretary.

Texas Association of Medical Anesthetists, Dallas, May, 1947. Dr. Claudia Potter, Temple, President; Dr. Russell Bonham, Box 6237, Houston, Secretary.

Texas Association of Obstetricians and Gynecologists, Galveston, November 2, 1946. Dr. Allen McMurrey, Houston, President; Dr. Julius McIver, 714 Medical Arts Building, Dallas, Secretary.

Texas Chapter, American College of Chest Physicians. Dr. R. G. McCorkle, San Antonio, President; Dr. Elliott Mendenhall, 1217 Medical Arts Bldg., Dallas, Secretary.

Texas Club of Internists. Dr. Robert M. Barton, Dallas, President; Dr. Julian C. Barton, 414 Navarro St., San Antonio, Secretary.

Texas Hospital Association, Houston, March 27-29, 1947. Tol Terrell, Harris Memorial Methodist Hospital, Fort Worth, President; Mrs. Ruth Barnhart, 720 College Ave., Dallas, Secretary.

Texas Neuropsychiatric Association, Dallas, May, 1947. Dr. Fred T. Rogers, Dallas, President; Dr. David Wade, 604 Capital National Bank Bldg., Austin, Secretary.

Texas Ophthalmological and Otolaryngological Society, Dallas, December, 1946. Dr. C. B. Williams, Mineral Wells, President; Dr. E. D. Dumas, 425 Medical Arts Bldg., San Antonio, Secretary.

Texas Orthopedic Society. Dr. E. A. Cayo, San Antonio, President; Dr. Edward Smith, 1215 Walker Ave., Houston, Secretary.

Texas Pediatric Society, Fort Worth, October 4-5, 1946. Dr. Max Woodward, Sherman, President; Dr. John E. Ashby, 3610 Fairmount, Dallas, Secretary.

Texas Public Health Association, Dallas. Dr. L. P. Walter, Austin, President; Mr. Earle W. Sudderth, Dallas County Health Department, Court House, Dallas, Secretary.

Texas Radiological Society, January, 1947. Dr. Herman Klapproth, Sherman, President; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secretary.

Texas Railway and Traumatic Surgical Association. Dr. F. L. Snyder, Fort Worth, President; Dr. Ross Trigg, First National Bank Bldg., Fort Worth, Secretary.

Texas Society for Mental Hygiene. Dr. Jack R. Ewalt, University of Texas Medical Branch, Galveston, President; Mrs. Elizabeth F. Gardner, 1617 Watchhill Road, Austin 21, Executive Secretary.

Texas Society of Gastro-Enterologists and Proctologists, Dallas, May, 1947. Dr. Tom E. Smith, Dallas, President; Dr. D. L. Curb, 704 Dallas Ave., Houston, Secretary.

Texas Society of Pathologists, Houston, January, 1947. Dr. May Owen, Fort Worth, President; Dr. C. T. Ashworth, Southwestern Medical College, Dallas, Secretary.

Texas State Heart Association, Dallas, May, 1947. Dr. Robert M. Barton, Dallas, President; Dr. M. B. Whitten, Medical Arts Bldg., Dallas, Secretary.

Texas Surgical Society, Houston, October 7-8, 1946. Dr. G. V. Brindley, Temple, President; Dr. Walter Stuck, 1426 Nix Professional Building, San Antonio, Secretary.

Texas Tuberculosis Association. Dr. J. B. White, Amarillo, President; Miss Pansy Nichols, 700 Brazos, Austin, Executive Secretary.

Third Panhandle, District Medical Society, Lubbock, October 8-9, 1946. Dr. W. A. Carroll, Claude, President; Dr. George Powers, Fisk Bldg., Amarillo, Secretary.

Fourth District Medical Society, Brady, November, 1946. Dr. H. L. Locker, Brownwood, President; Dr. Glenn H. Ricks, Brady, Secretary.

Seventh, Austin, District Society. Dr. Robert B. Morrison, Austin, President; Dr. M. I. Brown, Capital National Bank Bldg., Austin, Secretary.

Eighth, Ninth and Tenth Districts Medical Society, Orange, April, 1947. Dr. Walter F. Hasskarl, Brenham, President; Dr. George W. Waldron, Medical Arts Bldg., Houston, Secretary.

Eleventh District Society, Palestine, October 31, 1946. Dr. L. L. Travis, Jacksonville, President; Dr. C. B. Young, 929 S. Confederate, Tyler, Secretary.

Twelfth, Central Texas District Society, Temple, January 14, 1947. Dr. Thomas G. Glass, Marlin, President; Dr. H. F. Connally, Jr., Amicable Bldg., Waco. Secretary.

Thirteenth, Northwest District Society, Graham, October 24, 1946. Dr. A. L. Roberts, Fort Worth, President; Dr. Joe R. Wise, 1212 W. Lancaster, Fort Worth, Secretary.

Fourteenth District Society, Dallas, December 10, 1946. Dr. C. B. Thayer, Gainesville, President; Dr. V. L. Tuck, Sherman, Secretary.

Fifteenth, Northeast Texas, District Society, Marshall, October 8, 1946. Dr. Frank Littlejohn, Marshall, President; Dr. Henry H. Neihuss, Greggton, Secretary.

CLINICS

Dallas Southern Clinical Conference, Dallas, March 17-20, 1947. Miss Thelma J. Webb, 1133 Medical Arts Bldg., Dallas 1, Executive Secretary.

New Orleans Graduate Medical Assembly, New Orleans, February 24-27, 1947. Dr. Max M. Green, Room 105, 1430 Tulane Ave., New Orleans 13, Secretary.

Oklahoma City Clinical Society, Oklahoma City, October 28-31, 1946. Executive Secretary, 512 Medical Arts Bldg., Oklahoma City.

Post Graduate Medical Assembly of South Texas, Houston, December 3-5, 1946. Secretary, 229 Medical Arts Building, Houston.

HOSPITALS NEEDING INTERNS AND RESIDENTS

Methodist Hospital, Dallas. Capacity 206 beds. C. B. Fielder, Superintendent (interns desired, July, 1947).

El Paso City County Hospital, El Paso. Capacity 192 beds. George W. Cook, Col., U. S. A., Ret., Superintendent (3 interns for one year term, graduates of class A medical school only).

STATE BOARD OF MEDICAL EXAMINERS

The Texas State Board of Medical Examiners will hold an examination session in Austin on October 31, November 1 and 2, Dr. T. J. Crowe, secretary, announces.

MEDICAL OFFICERS RETURNING TO TEXAS*

(Corrections: Robert E. Casey, formerly of Galveston, has returned to Texas City; Thomas R. Jones, formerly of Beaumont, to Pineland; MacField McDaniel, formerly of May, to Pampa; Jake Shapira, formerly of Conroe, to Houston; W. O. Williams, formerly of Houston, to Dayton, Ohio.)

NAME	Serv.†	Location	Release Date
Bell County			
16. McElroy, Robert B.	A	Rogers	
Bexar County			
120. Bernard, George E.	N	San Antonio[1]	July, 1946
121. Berry, George W.	A	San Antonio	
122. Bloom, Bernard H.	A	San Antonio	
123. Gonzalez, Joaquin B.	A	San Antonio	
124. Jackson, Dudley	A	San Antonio	
125. King, Albert C.	A	San Antonio	
126. McCarroll, William H.	A	San Antonio	
127. O'Neill, James R.	N	San Antonio	
128. Polka, James B.	A	San Antonio	
129. Reinarz, Berthold H.	A	San Antonio	
130. Sacks, David R.	A	San Antonio	
131. Schiffer, Sydney	A	San Antonio	
132. Scull, Jackson	N	San Antonio[2]	
133. Stanton, William P.	A	San Antonio	
Bowie County			
5. Thompson, George W.	A	Texarkana	
Brazos-Robertson Counties			
6. Branch, George R., Jr.	A	Bryan	
Brooks-Duval-Jim Wells Counties			
10. Allison, Albert M.	A	Alice	
Clay-Montague-Wise Counties			
4. Ware, Drue O. D.	N	Bridgeport	May, 1946
Collin County			
7. Hooper, John M.	A	McKinney	
8. Truett, Harvey K.	A	McKinney	
Colorado-Fayette Counties			
5. Youens, William T.	A	Weimar	
Coryell County			
3. Cole, Marion W.	A	Evant	
Dallas County			
178. Blair, Drury S.	A	Dallas	
179. Blend, Max H.	A	Dallas	Jan., 1946
180. Caffee, William M.	A	Dallas	
181. Carswell, Winston E.	A	Dallas	
182. Clark, Arthur J.	A	Dallas	
183. De Lange, Arnotte	A	Dallas	
184. Dunstan, Edgar M.	A	Dallas	
185. Fiegel, Walter L.	A	Carrollton[3]	Dec., 1945
186. Fromm, Charles S.	A	Dallas	
187. Jansen, Harold G.	A	Dallas	
188. Kingsley, Roy E.	A	Dallas	
189. Lee, Richard H.	A	Dallas	
190. Lyle, Edward H.	A	Dallas	
191. McNamara, James C., Jr.	A	Dallas	
192. Metz, M. Hill		Dallas	
193. Patterson, Casey E.	A	Dallas	
194. Pence, Ludlow M.	A	Dallas	
195. Pickett, Walter F.	A	Dallas	
196. Porter, George L.	A	Dallas	
197. Stell, Cecil I.	N	Dallas	
198. Stovall, Sidney L.	A	Dallas	
199. Tobolowsky, Nathan	A	Dallas	July, 1946
200. Winans, Henry M.	A	Dallas	Dec., 1945
Dawson-Lynn-Terry-Gaines-Yoakum Counties			
8. Bennett, John B.	A	Lamesa	
9. Blackburn, M. D., Jr.	A	Seminole[4]	July, 1946
Ector-Midland-Martin-Howard-Andrews-Glasscock Counties			
12. Beadles, Robert O., Jr.	A	Big Spring	
13. Hestand, Haskell E.	A	Odessa	
14. Lekisch, Kurt	A	Midland	Apr, 1946
Ellis County			
7. Stein, Ben	A	Ferris[1]	
El Paso County			
52. Kearney, William W.	A	El Paso	
53. Oakes, Harold F.	A	El Paso	
54. Pangman, W. J.	N	El Paso	
Falls County			
7. Phillips, Oliver M.	A	Marlin	
Galveston County			
48. Blocker, Truman G.	A	Galveston	
49. Coffman, Graham M.	N	Galveston	
50. Kennedy, John C.	A	Galveston	
51. Laughlin, John M.	A	Texas City[2]	
52. Rogers, Frederick F.	A	Galveston	
53. Towler, Martin L.	A	Galveston	
54. Willis, James G.	A	Galveston	
55. Witten, Thomas A.	A	Galveston	
Gray-Wheeler Counties			
8. Nicholson, Harold E., Jr.	A	Wheeler	
Grayson County			
13. Stephens, George K.	A	Whitewright	
Gregg County			
14. Bussey, James E.	A	Longview	
15. Tate, George W.	A	Longview	
Hale-Floyd-Briscoe-Swisher Counties			
8. Richards, Fred V.	N	Tulia	June, 1946
Hardeman-Cottle-Foard-Motley Counties			
3. Harmon, F. C.	A	Paducah[3]	
Hardin-Tyler Counties			
3. Harrison, Albert W.	A	Woodville	
Harris County			
231. Brandon, Sylvan	A	Houston	
232. Candy, William M.	A	Houston	
233. Clapp, James A., Jr.	A	Houston	
234. Cutler, Hayden H.	A	Houston	
235. Fleet, Carl W.	A	Houston	
236. Giessel, Julius W.	A	Houston	Apr., 1946
237. Gilbert, Howard P.	A	Houston	
238. Green, Wilbur K.	A	Houston	
239. Hubner, Alan E.	A	Houston	
240. Jones, Robert R.	A	Pasadena	
241. Legett, Carey, Jr.	A	Houston	
242. Marcuse, Peter M.	A	Houston	
243. Mendell, David	A	Houston	
244. Oldham, Dudley Y.	A	Houston	
245. Robinson, H. C., Jr.	A	Houston	
246. Rogers, Stanley F.	N	Houston	
247. Rohrer, George E., Jr.	A	Houston	
248. Seibold, George J.	A	Houston[4]	Apr., 1946
249. Sharp, William E.	A	Houston	
250. Sherrill, Ethan A., Jr.	A	Houston	
251. Stork, Walter J.	A	Houston	
252. Strashun, Mat F.	A	Houston	Oct., 1946
253. Thorning, Wm. B., Jr.	A	Houston	
254. Wallis, William McV.	A	Houston	
255. Wilhite, Hilton R.	A	Houston[5]	Mar., 1946
Hill County			
5. Robertson, James E.	A	Hillsboro	
Hutchinson-Carson Counties			
3. Anderson, Elmo D.	A	Borger	
4. Martin, Leon H.	A	Borger	
Jefferson County			
50. Covode, William M.	A	Port Arthur	
51. Mitchell, Joseph H.	A	Beaumont	
52. Parker, George E.	A	Beaumont	
53. Tritico, Joseph J.	A	Port Arthur	Feb., 1946
54. Weisbach, Phillip T., Jr.	A	Port Arthur	Apr., 1946
Karnes-Wilson Counties			
6. Kauffmann, A. F., III	N	Kenedy	
Kerr-Kendall-Gillespie-Bandera Counties			
12. Barshay, Bernard	A	Kerrville	
13. Pucie, Charles R.	A	Kerrville	
Lamar County			
9. Johnson, Malcolm L.	A	Paris	
Lubbock-Crosby Counties			
21. Spikes, Lowell W.	A	Ralls[6]	

*EDITOR'S NOTE: This list is the eleventh of a series in which it is hoped to name all those physicians who have been in the Armed Forces during the war recently passed and have now returned to Texas to resume civilian practice. The information in this list has been assembled from a variety of sources. While an attempt has been made to secure as complete and as accurate data as possible, we are aware that omissions and errors have been made. Not only for publication in the JOURNAL but also for the permanent records in the central office of the State Medical Association, we invite and urge correction of and addition to the material here submitted. Note that physicians from each county area are numbered consecutively following those listed in the August JOURNAL; the last number in each section therefore indicates the total physicians returned to that county area. The complete total for Texas named to date (August 26), including the accompanying list, is 1,646.

†A=Army; N=Navy; U=U. S. Public Health Service.
[1]Formerly of Houston.
[2]Formerly of San Angelo.
[3]Formerly of Lewisville.
[4]Formerly of Dallas.

[1]Formerly of Tyler.
[2]Formerly of West Columbia.
[3]Formerly of Floydada.
[4]Formerly of Wichita Falls.
[5]Formerly of Hillsboro.
[6]Formerly of Lubbock.

NAME	Serv.†	Location	Release Date
McLennan County			
38. Allison, Harold T.	A	Waco	
39. Edwards, Thomas G.	A	McGregor	
40. Fine, Eldon B.	A	Waco[1]	
41. Hubbs, Roy S.	A	Waco	
42. Lewis, Claude	A	Waco	
Milam County			
3. Nail, D. M.	A	Cameron	
Morris County			
1. Moore, Rufus D., Jr.	A	Omaha	
Navarro County			
5. Barnebee, J. H.	A	Blooming Grove[2]	
Nolan-Fisher-Mitchell Counties			
10. Rhode, Oscar E.	A	Colorado	
Potter County			
29. Smith, Joseph R.	A	Amarillo	
San Patricio-Aransas-Refugio Counties			
9. Ewing, Ferdinand S.	A	Sinton	
Scurry-Dickens-Kent-Garza-Borden-King-Stonewall Counties			
8. Hines, John F.		Snyder[3]	
Shelby-San Augustine-Sabine Counties			
7. Arnold, Hiram P.	A	Hemphill	
Smith County			
12. Alexander, J. E., Jr.	A	Tyler	
13. Neill, John L.	N	Tyler	
14. Sehested, Herman C.	A	Tyler	
Tarrant County			
79. Aurin, Fred B.	A	Fort Worth	

[1]Formerly of Cleburne.
[2]Formerly of Houston.
[3]Formerly of Groesbeck.

NAME	Serv.†	Location	Release Date
Tarrant County—Continued			
80. Bailey, Noel R.	A	Fort Worth	May, 1946
81. Cohen, Frank	A	Fort Worth[1]	
82. Stokes, Robert C.	A	Fort Worth[2]	
Taylor-Jones Counties			
20. Estes, Jack M.	A	Abilene	
Tom Green-Coke-Crockett-Concho-Irion-Sterling-Sutton-Schleicher Counties			
16. Jones, Robert R.	A	San Angelo[3]	
17. Pruet, Royce W.	N	Ozona[4]	May, 1946
18. Shelton, Joel A.	A	Sonora	
19. White, James N.	A	San Angelo	
20. Woodward, Lewis O.	A	San Angelo	
Travis County			
45. Conolly, Sidney McLean	A	Austin	
46. Cooper, Samuel S.	A	Austin	
47. Darnall, Charles M.	A	Austin	
48. Martin, Claud A.	A	Austin	
49. Welty, John A.	A	Austin	
50. White, Paul L.	A	Austin	
51. Wilson, James D.	A	Austin	
Wharton-Jackson-Matagorda-Fort Bend Counties			
12. Harris, Hunter P.	A	Fulshear	
13. Lancaster, Lifford R.	A	Ganado	
14. Livengood, Gerald S.	A	Bay City	
15. Northington, Harold	A	Wharton	July, 1946
Wichita County			
24. Hargrave, Robert L.	A	Wichita Falls	
25. Kernodle, Jefferson D.	A	Wichita Falls	
Wood County			
3. Coleman, Robert H.	A	Little Rock, Ark.	July, 1946

[1]Formerly of Dallas.
[2]Formerly of Amarillo.
[3]Formerly of Houston.
[4]Formerly of Putnam.
[5]Formerly of Mineola.

TUMOR SEMINAR AT SAN ANTONIO

Dr. Emil Novak, Johns Hopkins University School of Medicine authority in the field of gynecologic pathology, will conduct the third annual tumor seminar sponsored by San Antonio pathologists, to be held October 19, in the auditorium of the Medical and Surgical Memorial Hospital, San Antonio. Dr. B. F. Stout, San Antonio, has announced that the seminar is open to any pathologist who wishes to attend.

Twenty-five slides, all illustrating gynecologic pathology, will be studied. A box of slides and a history of every case will be furnished each pathologist, but it will be necessary for guests to bring their own microscopes.

A lecture on "Functional Uterine Hemorrhage" will be delivered by Dr. Novak in an open meeting at the hospital at 8 o'clock in the evening.

CONGRESS ON INDUSTRIAL HEALTH

The Seventh Annual Congress on Industrial Health, sponsored by the American Medical Association's Council on Industrial Health, will be held at the Copley-Plaza Hotel, Boston, September 30 through October 2. The following program has been arranged by the council:

SEPTEMBER 30

Clinical Toxicological Conference: Lead Poisoning.
Surgical Conference: The Foot in Industry.
Professional Relations Conference and Dinner.

OCTOBER 1

Opening General Session: Human Relations in Industry.
Seminars: Industrial Physiology, Administrative Methods, Workmen's Compensation.
Dinner and Conference on Pan-American Industrial Health.

OCTOBER 2

General Session: Atomic Energy—Its Effects in Industry and Medicine.
General Session: A Positive Health Program for Industry.
Dinner and Conference on Health and Welfare Programs in Industry.

MILITARY SURGEONS CONVENTION

The Association of Military Surgeons of the United States will convene October 9-11 at the Book-Cadillac Hotel, Detroit. Physicians, surgeons, dentists, veterinarians, nurses, and medical administrators are invited by association officials to attend the meetings, banquets, luncheons, symposia, and panel discussions of the session. There is no registration fee, but reservations should be made promptly with Col. Burt R. Shurly, Chairman, Hotels Committee, 1005 Stroh Building, Detroit 26.

Luncheons, teas, sightseeing trips, and other entertainment have been planned for women whose husbands are attending the convention.

OKLAHOMA CITY CLINICAL CONFERENCE

The Oklahoma City Clinical Society will hold its sixteenth annual conference October 28-31 in the Biltmore Hotel, Oklahoma City. Dr. Harrison H. Shoulders, Nashville, Tenn., president of the American Medical Association, will be one of seventeen nationally recognized physicians and specialists appearing on the program, which will consist of general assemblies, postgraduate courses, round-table luncheons, a smoker, and dinners. Commercial exhibits will also be displayed. A $10 registration fee covers the entire conference activities. Additional information may be secured from the Executive Secretary, 512 Medical Arts Building, Oklahoma City.

AMERICAN PUBLIC HEALTH ASSOCIATION

The American Public Health Association will meet in Cleveland, November 12-14, with eleven related organizations and conferences scheduled for November 11, announcement from association headquarters reveals. Special topics for the program include the health department and medical care, newer developments in the control of tuberculosis and venereal disease, "one world in health," and "landmarks of 1946." Technical and scientific exhibits and motion pictures will be displayed.

STREPTOMYCIN AVAILABLE

Streptomycin will be available in limited commercial distribution after September 1, according to announcement in *The Journal of the American Medical Association*. The drug will be issued to selected hospitals throughout the country, which will act as depots.

DALLAS HEALTH MUSEUM

Making Health "visible, audible, and intelligible" is the object of the Dallas Health Museum, which will be open for the first time during the State Fair of Texas, October 5-20. It will be housed in the former Museum of Natural Resources Building in Fair Park, Dallas, near the Ranger station, and will be a permanent institution.

Although plans call for a separate charter with a full-time director and assistants to operate the museum, the project is being launched by the Dallas Academy of Medicine, established only last June. The initial exhibits are being prepared by the various groups which coöperate in the academy: Dallas County Medical Society, Dallas County Dental Society, Dallas Hospital Council, Dallas Nurses Association, Dallas County Pharmaceutical Association, and Medical Service Society. As far as is known the academy is the only organization in the nation which unites all such related groups and furnishes a channel through which they can work together on common objectives.

The Dallas Health Museum, which will open October 5.

In inviting Texas physicians to visit the new Health Museum, especially when they attend the State Fair in October, Dr. Oscar M. Marchman, president of the Dallas Academy of Medicine, points out that a health museum is a school with the whole community as its pupils. The Dallas Health Museum will convey the messages of good health to all the citizens of Dallas and the Southwest through artistic exhibits, three dimensional sculpture, motion pictures, lectures, and demonstrations. Dr. Marchman anticipates that the Museum will serve particularly well when the advent of new disease threats or sanitation problems make of prime importance the education of the public in health matters.

Another immediate project of the Dallas Academy of Medicine is the erection of a $500,000 building adjacent to the Southwestern Medical Foundation, which will contain the offices of the various health organizations which are members of the academy, a medical library, an auditorium, and several small meeting rooms.

In addition to Dr. Marchman as president, the academy recently elected Dr. Henry L. Rice as vice-president and W. Ray Spears as secretary-treasurer.

EFFECT OF JAPANESE IMPRISONMENT

Three years in Japanese prison camps, most of the time on starvation rations and subjected to frequent beatings, had surprisingly little effect on the minds of more than 4,000 American soldiers who survived the ordeal.

Wherever these men landed in the United States after liberation they were met by teams of medical specialists assigned from the office of the Surgeon General. A report on the neuropsychiatric findings has just been made by Lt. Col. Norman Q. Brill, who was in charge of this phase of the examinations.

Considerable importance was attached to early medical contact with the released soldiers because, says Dr. Brill, "never before in this country's history had such a large group been exposed to starvation, torture, and humiliation." The psychiatrists were interested in the factors that were responsible for the survival of these men when so many of their comrades, in about the same physical condition when captured, had succumbed. The nearest they came to finding a common factor, however, was what is described in the report as a "tremendous will to live." Otherwise the soldiers differed in about every possible way.

"All of them," says Colonel Brill's report, "lived only for the day. Indeed when one of them would fail to concentrate on or begin to hoard food, or gave way to morbid thoughts concerning the seemingly hopeless situation, he was earmarked by his companions as quite likely to die shortly. A prisoner who would hoard his rice allowance for several meals in order to enjoy the sensation of one large meal was referred to as 'rice happy.' This was generally an indication of the beginning of deterioration and early demise.

"When those of lesser spiritual strength became ill they were likely to give up, quit eating entirely, and frequently would die within a few days. One fails to find a scientific reason or an adequate term to explain survival. It seemed to some of the examiners that 'courage' was the best word. It seemed that the only common factor among the survivors was that they had courage. They never stopped in their struggle for survival. They ate anything available including cats, dogs, silk worms, and other things repulsive to normal human beings. When struck with dysentery and malaria they would nevertheless attempt to carry on. This strength and courage had no connection with social background or education."

The men themselves, Colonel Brill said, expressed no concern about their ability to readjust to life in the United States. Regardless of the future, they felt, they would meet any situation likely to arise after living through the prison camp years.—S. G. O. Notes, May 15, 1946.

BLOOD CLOTTING IN VEINS

A Swedish physician's five year study reveals that patients suffering from acute venous thrombosis can be spared pain, ulcers, and even death, by treatment with heparin, one of the drugs which prevents blood clotting.

Gunnar Bauer, M. D., surgeon in chief of the General Hospital in Mariestad, Sweden, presents his report in the May 18 issue of *The Journal of the American Medical Association.*

Between October 1, 1940, and September 30, 1945, 209 cases of acute thrombosis of the deep veins of the leg were treated at the Mariestad Hospital. As a result of heparin treatment, pain, fever, and swelling were eliminated; the average period in bed was shortened from 40 days to about 4.7 days; the death rate was reduced to less than one tenth of what it was before.

The author reviewed a series of 264 patients with thrombosis treated by accepted methods over a 10 year period and found that 47 died. In the heparin treated group, covering a five year period, only three died.

Dr. Bauer made an intensive study to prove his theory that the starting point of the clotting process was in the lower part of the leg. X-ray diagnosis, used on 190 patients, showed in over 98 per cent various phases of evolution of the clot in this region.

The author suggests that this knowledge should be an important aid in diagnosing the disease in its early stage. Whenever there is a rise in temperature without any obvious reason, or a pain or stitch in one side of the chest, the lower part of the patient's leg should be immediately examined. X-rays are the only way to confirm the diagnosis. However, if swelling and blueness of the skin are present it indicates that the disease is in an advanced stage and unfortunately it is then often too late for treatment.

One of the unpleasant after-effects of this disease has always been ulcers of the leg. Dr. Bauer states that from 80 to 90 per cent of leg ulcers which are thought to be due to varicose veins are really caused by an earlier deep thrombosis. Heparin treatment clears up the infection in a few days and eliminates such painful and incapacitating developments in the future.

The author summarizes his suggested method of treatment in four steps: "(1) early diagnosis, (2) immediate intensive heparinization (by injection into the veins), (3) movements of the leg from the beginning, and (4) getting the patient out of bed the moment the acute thrombosis symptoms disappear, before the termination of heparin injections."

INTER-AMERICAN CARDIOLOGY CONGRESS

The Second Inter-American Congress of Cardiology will convene October 6-12 in Mexico City, sponsored by various cardiology societies of North, Central, and South America. The first congress was held when the National Institute of Cardiology was dedicated in Mexico City in 1944, at which time the Inter-American Society of Cardiology was established. Ten delegates from the United States, including Drs. G. R. Herrmann, Galveston; T. R. Harrison and Arthur Grollman, Dallas; and Joseph Kopecky, San Antonio, became charter members, Dr. Herrmann reports.

Essayists will include outstanding clinicians of Europe as well as of the Western Hemisphere. Dr. Herrmann and perhaps Dr. Grollman will present papers. Papers may be read in English, Spanish, French, or Portuguese, but will all be summarized in English.

Information regarding the Congress may be secured from the Central Committee, National Institute of Cardiology, Calzada de la Piedad 300, Mexico, D.F.

RADAR WAVES HARMLESS

Ten centimeter electro-magnetic waves, such as constitute radar pulses, apparently are harmless. This has been determined by intensive exposures of guinea pigs to this radiation at the Aero Medical Laboratory at Wright Field. The experiments are described in a report just made to the office of the Surgeon General by Lt. Col. Richard H. Follis, now of Duke University.

These extremely short radio waves first came into extensive use during the war in military equipment and army and navy personnel necessarily were exposed to them for long periods. Their biological effects were entirely unknown, although there was no reason to suppose that they would be in any way detrimental. Nevertheless disquieting rumors arose and attained considerable circulation that long exposure to the radiation might cause baldness or even sterility. Presumably the rumors were due to confusion with known effects of x-rays and ultraviolet radiation, both of which are at the other end of the spectrum. There, wave lengths are much less than those of visible light whereas the ten centimeter waves are thousands of times longer, and are called "short" only in comparison with other radio waves.

At the Wright Field laboratory Dr. Follis exposed 13 male guinea pigs to ten centimeter radiation three hours daily for from 51 to 53 days. At the end of this time they were killed and every vital organ studied. Absolutely no deviations from the normal were found. There was no loss of hair, and no evidence of sterility. It also was determined that no x-radiation, which might have been harmful, was mixed with the radio waves. There is no reason to suppose that human beings would be affected differently from the experimental animals.

Early in the war clinical studies were made of Navy volunteers exposed for long periods to high frequency radio waves, although not in measured amounts such as were used in the guinea pig experiments. No pathological effects were found. Some of the subjects had complained of headaches after several hours of exposure, but these disappeared shortly after exposure was ended.—S. G. O. Notes, May 15, 1946.

LIBRARY NOTES

The package library consists of collections of reprints and other periodical material on various subjects, prepared for lending to members of the Association. Requests for packages should be addressed "Library, State Medical Association of Texas, 1404 W. El Paso Street, Fort Worth, Texas." Twenty-five cents in stamps should be enclosed with the request to cover postage and part of the expense of collecting the material. Only one package may be borrowed at a time, and packages are allowed to remain in the hands of the borrower for 14 days.

Package Service

Packages were mailed from the Library of the State Medical Association of Texas during August, to the following:

Dr. Holloway Bush, McKinney—*Blood Sugar, hypoglycemia* (8 articles).

Dr. Hervey W. Dietrich, El Paso—(1 journal).

Dr. Thurman A. Kinder, Jr., Brownsville—*Paralysis, cerebral* (21 articles).

Dr. J. T. Krueger, Lubbock—*Adrenals, cancer* (9 articles).

Dr. Denman C. Hucherson, Houston—*Pelvis, fractures* (12 articles).

Dr. Ernestine Smith, Amarillo—*Tuberculosis, Pulmonary, therapy* (6 articles); *Streptomycin* (4 articles).

Dr. R. R. Lovelady, Santa Anna—*Amyloidosis* (18 articles).

Dr. Paul H. Wedin, Houston—*Blood Pressure, High, therapy* (12 articles).

Dr. P. W. Malone, Big Spring—(13 journals).

Dr. U. J. Dowling, Amarillo—(1 journal).

Dr. Earl R. Cockerell, Abilene—(6 journals).

Dr. David L. White, San Marcos—*Sulfonamides* (17 articles).

Dr. J. R. Nicholson, San Antonio—*Urea* (13 articles; *Vitamin Bc* (15 articles).

Dr. Joe Shipman, Vernon—*Heparin* (23 articles).

Dr. Robert H. Bell, Palestine—*Surgery, postoperative care* (6 articles); *Sutures* (16 articles).

Mrs. Laura McElroy, Dallas—(1 journal).

Mr. Fulton E. Dye, Jr., College Station—*Medicine, socialized* (12 articles).

Dr. H. E. Rosser, Snyder—*Sprue* (11 articles).

Dr. Y. S. Jenkins, Taft—(2 journals).

Memorial Hospital Library, Corpus Christi—(1 journal).

Dr. John L. Dean, Jr., Crockett—(2 journals).

Dr. George M. Tulloch, Okmulgee, Okla.—(3 journals).

Dr. R. W. Burford, Dallas—*Herpes Zoster* (1 article).

Dr. J. E. Loveless, Slaton—*Burns, therapy* (9 articles).

Miss Ruby Richardson, Belton—*Medicine, socialized* (12 articles).

Mrs. J. A. Odom, Memphis—*Medicine, socialized* (12 articles).

Miss Marie Hopper, Avery—*Medicine, socialized* (12 articles).

Dr. J. W. Neeley, Pecos—*Anesthesia, procaine and procaine compounds* (7 articles); *Heart, blood supply* (12 articles).

Dr. F. O. McGehee, Houston—*Osteosclerosis, fragilis* (15 articles).

Dr. D. R. Swetland, Marlin—*Orthopedics* (28 articles).

Dr. V. E. Friedewald, Big Spring—*Diabetes Mellitus, therapy* (4 articles).

Dr. Fred W. Sutton, Beaumont—*Leprosy, therapy* (10 articles).

Dr. M. C. Overton, Pampa—*Sleep, disorders* (11 articles).

Dr. J. B. Birt, Harper—(1 journal).

Dr. Melba McNeil, Abilene—*Hernia, diaphragmatic* (11 articles).

Dr. J. D. Magee, Abilene—*Larynx, cancer* (9 articles.

Dr. Lorence W. Feller, Fredericksburg—*Sterility* (17 articles).

Dr. Robert F. Thompson, El Paso—*Prostate, cancer* (15 articles).

Dr. Ralph H. Homan, El Paso—*Coronary Vessels, occlusion* (7 articles).

Dr. G. F. Madding, San Angelo—*Liver, Kidney and Spleen, cysts* (15 articles).

Dr. M. Hoch, Smithville—*Paralysis, spastic* (10 articles).

Dr. Charles H. Brown, Wichita Falls—*Urination, incontinence* (23 articles).

Providence Hospital Library, Waco—*Sarcoma, fibrosarcoma* (7 articles); (1 journal); *Colon, surgery* (10 articles).

Southwestern Medical Library, Dallas—(5 journals); (1 journal).

Scott & White Clinic Library, Temple—(3 journals); (1 journal).

Dr. F. J. L. Blasingame, Wharton—*Trichinosis* (7 articles).

Dr. Jesson L. Stowe, El Paso—*Abortion, prevention* (12 articles).

ACCESSIONS

Chicago, American Medical Association—Council on Pharmacy and Chemistry Reports; New and Nonofficial Remedies.

Brooklyn, N. Y., Chemical Publishing Co.—Cusset: English-French and French-English Technical Dictionary.

SUMMARY

REPRINTS RECEIVED, 752.	LOCAL USERS, 36.
JOURNALS RECEIVED, 222.	BORROWERS BY MAIL, 47.
ITEMS CONSULTED, 472.	PACKAGES MAILED, 56.
ITEMS TAKEN OUT, 160.	ITEMS MAILED, 673.

TOTAL ITEMS CONSULTED AND MAILED, 1,247.

NEWS

Contributions to this department will be appreciated. News should be of general medical interest, such as public health activities, new hospitals, personal items of more than local value, etc. News for a particular number of the JOURNAL should be in the hands of the Editor not later than the fifteenth of the preceding month.

Tom Green County has allocated $7,000, an increase of $4,000, to the San Angelo-Tom Green County Health Unit, effective next January 1, according to the San Angelo *Standard*. The health unit began a new fiscal year July 1 with a total budget of $48,704, including an increase of about $3,000 in salaries.

The Veterans Administration Hospital at Waco has been assigned twenty-seven new medical officers of the Army and Navy to relieve the acute shortage of personnel among Veterans Administration medical staffs, reports the Waco *Tribune-Herald*. A new program will allow these physicians to receive residency training which may be applied toward receiving recognition by specialty boards. It is anticipated that additional physicians will be assigned to the hospital for residency in neuropsychiatry under a plan to provide permanent additions to the Veterans Administration medical staffs. Dr. Charles L. Yeager, until recently chief of neuropsychiatric service at Lawson General Hospital, Atlanta, Ga., will direct the residency program. He said a local program of several months duration will be offered for nurses aides, recreational workers, librarians, occupational therapists, physiotherapists, and volunteer workers to give them definite knowledge of psychiatric problems and methods of meeting them.

Hotel Dieu, El Paso, expects to construct a seven-story addition to the present hospital building and is conducting a campaign to solicit funds for that purpose, reports the El Paso *Times*.

A San Antonio Medical Center was one step nearer realization in July when the board of directors of the Chamber of Commerce accepted a report from the medical foundation committee and authorized the executive committee to proceed with organization and incorporation of a medical foundation for the city, the San Antonio *Express* states. Nine trustees not members of the medical profession will be selected by members of the Chamber of Commerce board of directors. The foundation will then be incorporated, and an initial fund of $50,000 will be raised. An expert medical surveyor to advise what projects the foundation should undertake will be employed, and an executive to administer business details will be hired. The expressed purposes of the foundation are to arouse a community consciousness of the imperative public medical necessities in the area, to improve the health of people in the section, to improve the care of sick persons of the community, to foster medical teaching, and to encourage and sponsor medical research.

The Texas Division, American Cancer Society executive committee has announced appointment of fifteen directors to supervise allocation and expenditure of funds in local areas throughout Texas, informs the Houston *Chronicle*. The directors include Drs. Paul Brindley, Chauncey D. Leake, Robert Moore, and John Sinclair, University of Texas Medical School; A. L. Dippel, W. H. Moursund, H. F. Poyner, and S. A. Wallace, Baylor University College of Medicine; Everett Fox, William L. Hart, Charles L. Martin, and William F. Mengert, Southwestern Medical College; Dudley Jackson, San Antonio; Charles Phillips, Temple; and Stanley J. Seeger, Texarkana.

The M. D. Anderson Hospital for Cancer Research, which will become a permanent part of the Texas Medical Center, has been placed under the directorship of Dr. Randolph Lee Clark, a native Texan recently released from the Army, in which his last assignment was as director of surgical research and of the department of surgery at the School of Aviation Medicine, Randolph Field, according to the Galveston *News*. The Board of Regents of the University of Texas, of which the M. D. Anderson Hospital is a part, appointed Dr. Clark to succeed Dr. E. W. Bertner, Houston, who has been acting director of the hospital since its establishment in 1942 by the Legislature following donation of $500,000 for such a hospital by the Anderson Foundation. Dr. Clark, a native of Hereford, took medical degrees at the Medical College of Virginia and the graduate school of the University of Minnesota, did graduate work at the University of Paris, and was associated with the Mayo Foundation for several years, among other professional activities. Dr. Clark expects to tour cancer institutes throughout the country during the fall to secure data for increasing the effectiveness of the M. D. Anderson

Hospital. Although not now a practicing physician, Mrs. Clark is also a doctor of medicine.

To show its appreciation of the time and abilities which Dr. Bertner has donated in the past four years to the establishment of the M. D. Anderson Hospital, the University of Texas Board of Regents in session at Austin on July 13 passed the following resolution:

"The resignation of Dr. E. W. Bertner as Acting Director of the M. D. Anderson Hospital for Cancer Research brings to a close one of the most distinguished and important services ever rendered the University of Texas.

"From the earliest inception of the hospital, Dr. Bertner has devoted to it abilities of the highest order for which he has declined all offers of compensation. He has found time for this service in a professional life already full of honor and responsibility, and through rare administrative talent and enthusiasm has brought the hospital to a position in public esteem where its future is assured beyond peradventure. His past devoted interest guarantees that his technical resignation will not deprive the hospital of his continuing care and support.

"The Board of Regents wishes to record its profound appreciation for his devoted and distinguished service to the University, and it is ordered that this resolution be spread upon the minutes in permanent testimony thereof."

A Hite Laboratory Building in the Texas Medical Center will be erected in conjunction with the M. D. Anderson Hospital, Dr. E. W. Bertner, president of the center, has announced through the Houston *Chronicle*. About $500,000 of the $700,000 willed to the University of Texas for cancer research by the late Mrs. Rosalie B. Hite of Houston will be used for the building. Tentative plans for such a building had been under consideration for some time, Dr. Bertner said, but announcement was made after a district court order in Austin gave the University Regents full authority to administer funds of the Hite endowment.

Texas Medical Center.—William A. Kirkland, executive vice-president of the First National Bank of Houston, has been named to the board of trustees of the Texas Medical Center, reports the Houston *Press*.

A Veterans Administration Hospital to be built adjacent to the Texas Medical Center has been approved by President Harry S. Truman, states the Houston *Press*. The hospital will cost approximately $7,000,000.

Baylor University College of Medicine juniors and seniors are securing practical experience as well as filling a distinct need by acting as nurses at Hermann Hospital with the approval of University officials, informs the Houston *Chronicle*. Fifteen male nurses are now on call for private duty when not involved with their medical studies. The director of nursing at the hospital indicated that the young men have proved popular with their employers and are easing a tight nursing situation.

University of Texas.—Dr. Jose R. de Valle, professor of pharmacology at the Instituto Butantan, Sao Paulo, Brazil, has spent several months in the Pharmacology and Tissue Culture Laboratories of the University of Texas Medical Branch as a part of his study in connection with a Guggenheim traveling fellowship.

A. Packchanian, Ph. D., director of the Laboratory of Microbiology, has been invited to give a series of lectures in Brazil during September on Chagas' disease in North America and on the differential diagnosis between Weil's disease, yellow fever, and jaundice. Dr. Packchanian has recently completed a preliminary survey of Chagas' disease in Texas, assisted by Dr. Piero Manginelli of the University of Sao Paulo, Brazil, and supported in part by the Houston Foundation and Jesse Jones.

W. A. Selle, Ph. D., professor of physiology, is surveying American medical centers under the auspices of the Baruch Committee for Physical Medicine to develop satisfactory methods for teaching the medical application of physics to undergraduate medical students.

Recent changes in the staff of the University of Texas Medical Branch announced by Chauncey D. Leake, Ph. D., vice-president and dean, include the resignation of Dr. Stephen Weisz, associate professor of neuropsychiatry and assistant director of the State Psychopathic Hospital, to become associated with Southwestern Medical College, Dallas; the resignation of W. D. Collings, Ph. D., professor of physiology, to become a member of the University of Iowa staff; the resignation of Thurlo Thomas, Ph. D., assistant professor of anatomy, to become professor of zoology and chairman of the department at Carlton College, Minnesota; the resignation of E. H. Frieden, Ph. D., research associate in dermatology and syphilology, to become associated with the Zoology Laboratory of Harvard University; the resignation of Arthur Whiteley, Ph. D., research associate in the Tissue Culture Laboratory, to accept a National Research Council fellowship at the California Institute of Technology; and the resignation of Dr. E. J. Lefeber, assistant professor of medicine and director of the Student Health Service, to become director of the Galveston clinic of the Veterans Administration.

Dr. A. N. Taylor, of the Physiology Department of the University of Texas School of Medicine, has received a grant of $3,000 from the Life Insurance Research Fund to continue his studies on blood circulation, informs the Galveston *Tribune*. Dr. Taylor and his associates in the department, Drs. Eric Ogden, D. W. Cowling, and R. J. Ralston, have demonstrated for the first time that the blood flow in the major parts of the body is more rapid in the stream center than in the sides next to blood vessel walls.

The Faculty Research Council of the University of Texas Medical Branch has issued a circular letter pointing to the need for funds for current research projects for which money may not be immediately available and for the initiation of major projects in new fields for which substantial support is necessary. The council, consisting of Drs. George M. Decherd (medicine), Robert M. Moore (surgery), Eric Ogden (physiology), J. Allen Scott (preventive medicine), Stephen Weisz (neuropsychiatry), and Robert I. Wise (bacteriology), administers and allocates a faculty research fund for which contributions are being solicited. Acknowledgment of donations will be made in the council's annual report and, when feasible, specific recognition will be made in publications resulting from research.

Southwestern Medical College has received two grants totaling $12,500 from the American Cancer Society for investigation and treatment of cancer with radioactive substances, according to the Dallas *Medical Journal*. A faculty member to establish a Department of Biophysics for clinical investigations using radioactive materials will be paid $6,000 from one grant, while $6,500 has been allotted for purchase of radium and accessories for the treatment of indigent patients.

Dr. Arthur Grollman, professor of medicine at Southwestern Medical College, left early in August to give a three weeks series of lectures and conduct clinics in Central America, primarily in Panama City and San Jose, Costa Rica.

Upon completion of its third year of medical education and scientific research in July, Southwestern Medical College reported 200 doctors graduated, including 134 in the Army program, 27 in the Navy, and 39 civilians. The staff has grown from 40 to 88 full-time members and 235 clinical members. The

current student body has increased from 160 to 208. More than 150 scientific papers written by faculty members have been accepted for publication by medical journals. A financial report showed $75,000 received from national foundations, pharmaceutical houses, and private benefactors for specific research projects during the past fiscal year in addition to the $306,002 annual budget expenditure by the foundation for the operation of the college and for research, according to the Oak Cliff *Tribune*. Research actively in progress at the present time includes studies of improved methods for the diagnosis and treatment of virus diseases, diseases of children, cardiovascular diseases, and the aging process in the cells of the body.

Personals

Dr. A. I. Folsom, Dallas, was installed as president of the American Urological Association at its 1946 session, *The Journal of the American Medical Association* reports.

Dr. C. H. Altheide, San Antonio, had an oil painting in the Eighth Annual Exhibition of the American Physicians Arts Association in San Francisco, July 1-5.

Dr. Walter A. Ostendorf, formerly of San Antonio, will be medical officer of the Civil Aeronautics Administration at Fort Worth, thus becoming one of the first two C. A. A. regional medical officers of the country, according to the San Antonio *Express*. Dr. Ostendorf has been with the C. A. A. in Washington since being released from the Army.

Dr. C. A. Dwyer, county psychiatrist, was named acting director of the Harris County Health Unit in June upon the resignation of *Dr. Harold A. Wood*, director, to accept a position as assistant medical director of the Red Cross office in St. Louis, the Houston *Chronicle* informs.

Dr. T. R. Burnett, health officer of Mission for the past ten years except when he was in active service during World War II, resigned effective July 1, states the Mission *Times*.

Dr. David M. Cowgill, former city health officer of Amarillo and more recently of Anchorage, Alaska, has assumed the directorship of the Abilene-Taylor County Health Unit, according to the Abilene *Reporter-News*.

Drs. George W. Parsons and *Perry Priest*, Texarkana, Texas, presented papers at the Arkansas Medical, Dental and Pharmaceutical Association annual session in Texarkana, July 10-12, reports the Texarkana *Gazette*.

Dr. Rawley W. Ward has been succeeded as Victoria County health officer by Dr. Roy S. Lander, recently released from military service, according to the Victoria *Advocate*. Dr. Ward resigned after serving as health officer for the past twelve years.

Dr. B. E. Pickett, Carrizo Springs, President-Elect of the State Medical Association, has been appointed by Governor Coke Stevenson to fill a vacancy on the State Board of Health, informs the Austin *American*.

Dr. Joaquin Gonzalez Cigarroa, Laredo, was honored at a surprise testimonial dinner party in the New Plaza Hotel in Laredo in July to celebrate his twenty-five years of medical practice, reports the Laredo *Times*.

Dr. H. C. Wilson, who has served the past few months as director of the Bowie-Texarkana Health Unit, has resigned to enter private practice at Hooks, states the Texarkana *News*.

Dr. D. K. Jamison, Denison, has resigned as division surgeon of the Katy Employes Hospital to devote his full time to private practice and to other business interests, which include ownership with his son of a dairy and creamery, the Denison *Herald* announces. *Dr. Charles Truett*, a recent addition to the hospital staff, will succeed Dr. Jamison.

Dr. L. W. Leggett has purchased the Thomas Building in Midland from *Dr. John B. Thomas*, according to the Midland *Reporter-Telegram*. Dr. Leggett will maintain his offices in the building, which houses oil company offices and other business firms as well as professional offices.

Dr. Perry C. Talkington, Dallas (neuropsychiatry), and *Robert M. Moore*, Galveston (general surgery), for the Fourth Army area, and *Drs. Roy G. Giles* (x-ray), *John L. Matthews* (ophthalmology), *Samuel F. Moore* (obstetrics), *Lawrence M. Shefts* (thoracic surgery), *Walter G. Stuck* (orthopedics), and *Charles S. Venable* (general surgery), all of San Antonio, for Brooke General Hospital, Fort Sam Houston, have been appointed consultants to the Secretary of War through the Surgeon General, the War Department has announced.

Marriages

Dr. J. C. A. Eckhart, Jr., of Austin, on duty in Corpus Christi with the Naval Reserve, married Miss Ada Jane Williams, Galveston, on July 27.

Dr. John Wetegrove, Jr., formerly of Raymondville and now an intern at Baylor Hospital, Dallas, married Miss Dorothy Eldridge, Mercedes, on June 17.

Dr. Mose H. Blaine, Dallas, married *Dr. Alva Lockhart*, Pharr, on June 16. Both will intern at Baylor Hospital, Dallas.

Dr. John Marvin Smith, Jr., San Antonio, married Miss Jane Jordan, Victoria, on March 24.

SOCIETY NEWS

Bastrop County Society

July 5, 1946

(Reported by Joe V. Fleming, Secretary)

Bastrop County Medical Society members were entertained at dinner by Smithville physicians at the Pines Hotel, Smithville, July 5. Eleven members, wives, and guests heard Joe V. Fleming, Elgin, discuss the legislative program of the State Medical Association, especially the basic science bill proposed for introduction in the next Legislature. A resolution supporting the program was unanimously passed, and it was agreed that the newspapers in the county and the local candidates for the Legislature would be notified of the action.

Bexar County Society

July 16, 1946

Bexar County Medical Society and Auxiliary met July 16 at the Medical Library in San Antonio to hear C. C. Cody, Houston, President of the State Medical Association, discuss the proposed basic science law. Merton M. Minter, San Antonio, chairman of the State Medical Association's Public Relations Committee, spoke on the Wagner-Murray-Dingell bill, and John Burleson, San Antonio, chairman of the Legislative Committee, discussed local candidates for representative. V. H. Tucker, president of the Bexar County Medical Society, presided. About 225 were present.

Bowie County Society

Bowie County Medical Society and Miller County Medical Society of Arkansas have notified the city councils of Texarkana that they are 100 per cent behind a campaign to clean up the city and get rid of filth and preventable diseases. In a letter from the societies to the city officials and to the press the societies pointed out the highly insanitary sewage conditions which exist in varous parts of the city, the unsatisfactory system of garbage disposal, and the inadequate organization for enforcement of sanitary measures.

Colorado-Fayette Counties Society

June 25, 1946

Diseases of the Small Intestine and Dysentery—Herbert M. Hill, San Antonio.

Colorado-Fayette Counties Medical Society met

June 25 in Methodist Hall, Columbus, with Leo Peters, Schulenberg, president, presiding. The program, directed by S. H. Kirkham, consisted of a talk on intestinal diseases by Herbert M. Hill, San Antonio. Announcement was made of a meeting for discussion of the proposed basic science law to be held July 2. A chicken barbecue supper with the auxiliary was enjoyed following the business meeting.

Harris County Society

Harris County Medical Society has set up a ten-member board from its membership to hear complaints and make adjustments on claims by patients that they have been overcharged by their physicians. Announcement of the new plan was made in July by John M. Trible, chairman of the legislative and public health committee. He said that complaints will be received at the office of the medical society secretary and that the board will meet on call to hear both sides of the case after making an independent investigation. Consideration will be given to the patient's ability to pay and recommendations for adjustments will be made only after a study has been made of the patient's income and other obligations. The decision of the board will not be final, Dr. Trible pointed out. The patient can take his complaint to the medical society and even to the State Medical Association. Dr. Trible believed the Harris County board to be the first of its kind in Texas.

Pecos-Jeff Davis-Presidio-Brewster Counties Society

June 16, 1946

Pulmonary Embolism—Henry Leopold, San Antonio.

Pecos-Jeff Davis-Presidio-Brewster Counties Medical Society members and a few other guests were entertained by Dr. and Mrs. L. A. Lavanture with a steak dinner at the Crews Hotel, Marfa, June 16. The dinner was to honor the Lavantures' son-in-law and daughter, Dr. and Mrs. Henry Leopold, San Antonio.

Dr. W. E. Lockhart, Alpine, president of the society, presented Dr. Leopold, who read a paper in which the history of methods of treating pulmonary embolism was reviewed and his own experiences in treating the disease were discussed. At the request of the society, Dr. Leopold also told something of the epidemic with which San Antonio has been confronted recently.

Taylor-Jones Counties Society

July 17, 1946

Hernia, a Surgical Problem—R. W. Varner, Abilene.
Newer Advances in Treatment of Anemia—L. J. Webster, Abilene.
Diagnosis and Treatment of Corneal Foreign Bodies—J. D. Magee, Abilene.
Athlete's Foot—Earl R. Cockerell, Abilene.
Physiological Changes of Senescence—C. A. McFadden, Abilene.
Selected Subjects—John Chapman, Henry Winans, and Robert S. Sparkman, Southwestern Medical College, Dallas.

Taylor-Jones Counties Medical Society held its annual midsummer clinic at Hendrick Memorial Hospital, Abilene, July 17, with more than sixty physicians from West Texas in attendance. The morning session was devoted to papers by five Abilene physicians, while the afternoon program consisted of three papers by members of the Southwestern Medical College faculty. The guest speakers were also available for discussions and questions.

Abilene physicians and their wives were hosts to the Dallas visitors for dinner and entertainment at the Abilene Country Club following the clinic. W. A. V. Cash and L. J. Pickard were in charge of arrangements.

Twelfth District Society

July 9, 1946

(Reported by H. F. Connally, Jr., Secretary)

Twelfth District Medical Society members numbered more than sixty at a one-day meeting in Corsicana on July 9, at which T. G. Glass, Marlin, president, presided. The following scientific program was carried out:

Early Ambulation in Surgery—R. B. Grant, Bryan.
Postoperative Intravascular Clotting—H. H. Trippet, Waco.
Common Eye, Ear, Nose, and Throat Misconceptions—E. R. Veirs, Temple.
Diagnosis and Treatment of Gout—N. D. Buie and A. E. Von Tobel, Marlin.
Preliminary Report on the Treatment of Paralyzed Muscles in Anterior Poliomyelitis by Temporary Procaine Paralysis Spasmodic (Good) Muscles—H. E. Hipps, Waco.
Some Problems in the Diagnosis of Brucellosis—G. H. Sanders, Kerens.

H. Frank Carman, Dallas, spoke on "Development of Our Ideas Regarding Tuberculosis" at a luncheon given by Navarro County Medical Society for the District Medical Society and Auxiliary.

An invitation from Temple, extended by Drs. Veirs and G. V. Brindley, to hold the next meeting of the society there January 14, 1947, was accepted. The same officers, Dr. Glass, president, and H. F. Connally, Jr., Waco, secretary, will continue to serve until January.

Arrangements for the Corsicana meetings were made by E. H. Newton, W. K. Logsdon, and W. R. Sneed.

AUXILIARY NOTES

Officers of the Woman's Auxiliary to the State Medical Association of Texas: President, Mrs. George Turner, El Paso; President-Elect, Mrs. Edward C. Ferguson, Beaumont; First Vice-President, Mrs. L. B. Windham, Tyler; Second Vice-President, Mrs. V. M. Longmire, Temple; Third Vice-President, Mrs. R. E. Clark, Memphis; Fourth Vice-President, Mrs. J. E. Hogan, Big Spring; Corresponding Secretary, Mrs. Robert F. Thompson, El Paso; Recording Secretary, Mrs. M. A. Ramsdell, San Antonio; Publicity Secretary, Mrs. J. F. Campbell, Fort Worth; Treasurer, Mrs. Guy Jones, Dallas; Parliamentarian, Mrs. Joe Nichols, Atlanta.

AUXILIARY NEWS

Bexar County Auxiliary board members and committee chairmen numbering thirty met May 24 as guests of the new president, Mrs. Dan Russell, for luncheon at the San Antonio Country Club. In a business meeting preceding the luncheon the group made plans for the year. It was decided to hold a board meeting the fourth Friday of every month prior to each meeting of the auxiliary and for each committee worker to keep notes throughout her term of office to make suggestions to her successor.

Bexar County Auxiliary met jointly with the Bexar County Medical Society on July 16 on the lawn of the Medical Library. Dr. V. H. Tucker, president of the society, presided. He introduced Mrs. Dan Russell, president of the auxiliary, who in turn introduced Mrs. Frank Haggard, chairman of the State Auxiliary School of Instruction Committee. Dr. Merton M. Minter, chairman of the Public Relations Committee of the State Medical Association, spoke on the Wagner-Murray-Dingell bill, and Dr. John Burleson, chairman of the State Medical Assosiation's Legislative Committee, discussed the local candidates for representatives. The principal speaker of the evening, Dr. C. C. Cody of Houston, President of the State Medical Association, spoke on the medical practice act. Tamales and beer were served to 225 after the meeting. Mrs. John L. Pridgen was in charge of arrangements.—Mrs. R. J. Gossett, publicity secretary.

Colorado-Fayette Counties Auxiliary heard a discussion of "The Role of the Auxiliary in the Future of American Medicine—A Challenge," by Mrs. S. H. Kirkham, when it met June 25 at Columbus. Mrs. James H. Wooten, Jr., president, read the constitution of the State Medical Auxiliary, and the local group decided to draw up its own constitution in the near future. The auxiliary joined the medical society

for a chicken barbecue supper following the meeting.

Gregg County Auxiliary held its first postwar meeting July 16 at the Longview home of Mrs. Ben Andres, retiring president. New officers elected include Mrs. W. P. Farrar, president; Mrs. W. M. Routon, Kilgore, vice-president; Mrs. R. C. Crawford, secretary; Mrs. W. M. Cole, treasurer; and Mrs. John Wensley, publicity chairman. Eleven guests were served iced "cokes," open face sandwiches, potato chips, salted nuts, and miniature cinnamon rolls. Asters in shades of purple centered the dining table and multicolored garden flowers decorated the rooms.

Twelfth District Auxiliary met in Corsicana on July 9, holding a business session at Corsicana Country Club in the morning; joining the Medical Society for a luncheon given by Navarro County Medical Society, at which Dr. H. Frank Carman, Dallas, spoke on tuberculosis; and being entertained in the afternoon at the home of Mrs. W. K. Logsdon. Assisting Mrs. Logsdon with arrangements were Mesdames W. R. Sneed and L. E. Kelton, Jr.

Mrs. R. B. Homan, El Paso, for many years active in medical auxiliary work, died July 31, 1946. Mrs. Homan served on various committees of the State Auxiliary prior to becoming its president for the 1936-1937 term. She was Council Woman of the El Paso District for four terms and helped organize the El Paso County Auxiliary in 1922. In 1928 she was elected honorary life president of the county auxiliary. Mrs. Homan was the mother of Dr. R. B. Homan, Jr., of El Paso.

Mrs. M. P. Schuster, 82, pioneer El Pasoan and past president of El Paso County Auxiliary, died July 29, 1946, after a short illness. She was particularly interested in Pan-American activities, was a past president of the Women's Club, and a member of the Presbyterian Church, Chamber of Commerce, Charity Association of El Paso, and the old Civic Club. She is survived by two sons, Drs. S. A. and Frank Schuster; two daughters, Mrs. Regina Schuster Rabb and Mrs. Margaret Schuster Marshall, all of El Paso; nine grandchildren; and three great-grandchildren.

BOOK NOTES

New and Nonofficial Remedies, 1946, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1946. Cloth, 770 pages. Price, postpaid, $1.50. Chicago, American Medical Association, 1946.

"New and Nonofficial Remedies" is the book in which are listed and described the medicinal preparations which the Council on Pharmacy and Chemistry has found acceptable, under its rules, for the use of physicians. To have a product accepted, the manufacturer must declare its composition, give adequate proof of its therapeutic value, and market it with claims which have been found valid by the Council. The present volume represents a cumulative epitome of the Council's work since its foundation in 1905.

Accepted preparations are grouped in twenty-four classifications ranging from Allergenic Preparations to Vitamins. Ordinarily, an inclusive general article precedes the description of the various products. The monograph for the products sets forth the actions, uses, and dosage and usually a set of tests and standards. As its name implies, the book is intended to describe nonofficial preparations, that is preparations which are not included in such official publications as the "Pharmacopeia" and the "National Formulary." However, some official articles are listed and described, these being in general those for which the Council feels the practicing physician needs concise and authoritative information. In the preface of the present volume, the Council lists some thirty-five official drugs ranging from acetylsalicylic acid to Strophanthin, which the Council feels it no longer necessary to consider for inclusion in the book. However, in most cases, a brief monograph on actions, uses, and dosage gives information useful to the physician and for the control and advertising of marketed preparations.

Examination of the volume reveals that there have been no extensive or radical revisions of the general articles representing the twenty-four chapter heads under which preparations are classified. A few revisions of separate monographs may be mentioned: under Chaulmoogra Derivatives, the recommended use of Chaulmoogra Oil is limited to sarcoidosis; the dosage statement for Quinacrine Hydrochloride has been notably expanded to reflect the wartime experience with the drug. The radically revised monograph on Amphetamine is in harmony with the recent Council report on the use of this drug. Minor revisions of the chapter on Contraceptives are noted, and one marks the appearance of many additional products. The monograph on the Vitamin B Complex now mentions synthetic folic acid, recently made available for investigational use, but no accepted preparations are listed.

There appear to be no spectacularly new accepted preparations. Perhaps the most noteworthy is the casein hydrolysate, Amigen, acceptance of which will no doubt be followed by that of many more preparations representing the field of amino acid therapy.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1945. Cloth, 122 pages. Price, postpaid, $1.00. Chicago, American Medical Association, 1946.

Originally intended chiefly as a repository of its reports on rejection of preparations found unacceptable for inclusion in "New and Nonofficial Remedies" or of status reports on products whose therapeutic value has not yet been established, this volume in recent years has been composed mainly of reports giving general information to the physician on the status of various therapeutic agents and therapeutic procedures. Most of these reports have previously been published in *The Journal of the American Medical Association*. The reports in the present volume emphasize the educational nature of the Council's work and bear witness to its leadership in the consideration of current therapeutic problems.

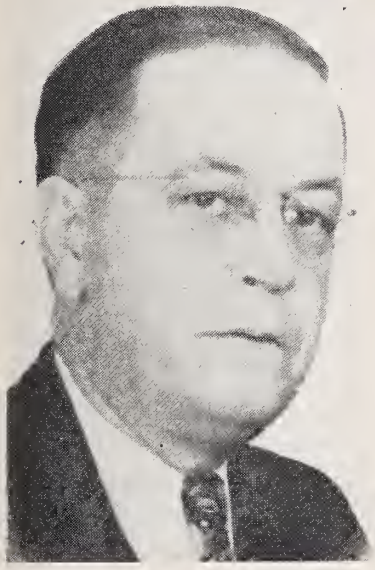
The report "Dermatophytosis: Treatment and Prophylaxis," gives a concise estimate of progress in this field and sets up useful standards for the evaluation of fungicidal preparations. The report on "Dangers from the External Use of Sulfonamides," obviously stems from wartime experience with these preparations and issues a warning against over-the-counter sales. The report "Status of Poison Ivy Extracts" emphasizes the fact that these preparations are to be used in prevention rather than treatment. The report on Acne Bacillus Vaccine points out that this preparation, in the opinion of most investigators, fails in most cases clinically to arrest or control acne vulgaris. In the report "The Status of Passive Immunization and Treatment in Pertussis by the Use of Human Hyperimmune Serum" prepared by Dr. Harriet M. Felton and sponsored by the Council, the status of these preparations was definitively outlined just prior to the acceptance by the Council of a number of commercial preparations.

This volume as well as preceding Annual Reprints are of interest not only to physicians but also to pharmacists, chemists, and pharmaceutical manufacturers, in fact to all who are interested in the progress of drug therapy.

DEATHS*

Dr. Thomas Spaulding Williams, Dallas, Texas, died July 18, 1946, in a Dallas hospital of coronary occlusion complicated with peritonitis following an attack of diverticulitis.

Dr. Williams, son of Dr. Eugene and Annie Williams, was born October 9, 1890, at Kingston, Hunt County, Texas. He attended high school at Celeste and received his medical education from the Medical Department of Southern Methodist University, where he was graduated May 30, 1912. Immediately following his graduation he served a one year internship at St. Paul's Hospital, Dallas, and then began his practice in that city. During World War I he served in the British Army as assistant surgeon at Fuse Hill Hospital, Carlisle, England, and with the 61st Division, Gordon Highlanders. On his return to the United States in 1919 he was commissioned assistant surgeon, U. S. Public Health Service in Dallas. He had continued to practice in Dallas until his death. Dr. Williams did postgraduate work at the New York School of Medicine.



DR. THOMAS S. WILLIAMS

Since 1918 Dr. Williams was a member of the State Medical Association and American Medical Association through Dallas County Medical Society. He was a member of the St. Paul's Hospital staff for more than thirty years, a member of the Methodist Hospital staff, on the Dallas Board of Health for ten years, and a member of the Methodist Church.

Dr. Williams on December 31, 1913, married Miss Frances Dole, of Dallas, who survives. Also surviving are his mother, Mrs. Annie Williams, and a sister, Mrs. E. T. Fry, Sr., both of Greenville.

Dr. Hatch Whitfield Cummings died July 29, 1946, at his home in Hearne, Texas, of arteriosclerosis.

Dr. Cummings was born September 14, 1869, in Aberdeen, Miss., the son of Mason Monroe and Amelia (Watkins) Cummings. His early education was received in the public schools of Fulton, Miss. His medical education was obtained in the medical department of the University of Tennessee, from which he was graduated in 1892. During his professional career he had taken postgraduate work in the New York Polyclinic and clinical centers in Chicago, New Orleans, and Philadelphia. He had been a regular attendant during his years of active practice at Annual Sessions of the State Medical Association and at postgraduate clinics in Dallas and Houston.

Shortly after his graduation he located in Hearne, Texas, where he was in active practice for fifty-two years. In addition to a busy general practice he served for many years as local surgeon for the Missouri Pacific and Southern Pacific Railways. He had been retired for the past few years because of his health.

DR. H. W. CUMMINGS

Dr. Cummings was one of the organizers and first president of the Brazos Valley Medical Association in 1896. He was a lifelong member of the American Medical Association and the State Medical Association. He was a charter member of the Brazos-Robertson Counties Medical Society, which he served as president continuously from 1927 through 1931. Dr. Cummings served his county medical society also as a delegate to the State Medical Association for many years. He was Chairman of the Section on State Medicine and Public Hygiene of the State Medical Association in 1910 and again in 1919. He also served the State Medical Association as Councilor of the Eleventh District from 1906 to 1907 and Councilor of the Twelfth District from 1907 to 1908. He was president of the State Medical Association in the years 1908-1909.

In addition to these offices held in the State Medical Association, perhaps the most outstanding service rendered by Dr. Cummings to the Association was in legislative work. He was a member of the Committee on Legislation and Public Instruction of the Association from 1923 to 1925. After the establishment of the present Legislative Committee of the State Medical Association, taking the place of this committee, he served continuously as its chairman from 1925 to 1942. During these years, Dr. Cummings gave abundantly of his time, talents, and wise counsel in all legislative matters in which the Association was interested. He made innumerable trips to Austin to represent the Association in hearings on important medical and public health bills.

Dr. Cummings served the state of Texas in important capacities. He was a member of the State Board of Health from 1909 to 1911. He served as a member of the Texas State Board of Medical Examiners from 1925 to 1935, and as president of the Board from 1927 through 1930. During his tenure of office on the Board he had served on all of its important committees.

In addition to a busy general practice and his many contributions to medical organizations and the state, Dr. Cummings found time for leadership in civic and community affairs. He served as president of the Hearne School Board for eighteen years. He was also president of the Hearne Building and Loan Association for thirty-five years, of the Planters and Merchants State Bank, Chamber of Com-

*An obituary ordinarily will not be published more than four months after date of death. Coöperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

merce, Rotary Club, and X-All Highwav Association. He had been a member of the Board of Stewards of the Hearne Methodist Church since 1894 and had served as president of the Board for many years. He had also served as superintendent of the Sunday school. He took an active interest in political affairs of the community and the state and served for six years as a member of the State Democratic Executive Committee.

Dr. Cummings was married December 21, 1897, to Miss Pauline Eckerle at Hearne. He is survived by his wife; one son, Dr. H. W. Cummings, Jr., Houston; four daughters, Mrs. A. B. Swanson, Austin; Mrs. E. Ghent Graves, Houston; Mrs. T. P. Haynie, Jr., Hearne; Mrs. John A. Barclay, Austin; eight grandchildren; and one great grandchild. He is also survived by a brother, B. Y. Cummings, Dallas; and two sisters, Mrs. George A. Duren, Dallas, and Mrs. Sam A. Montgomery, Houston.

Dr. John Burr Miller, San Antonio, Texas, died June 11, 1946, of malignancy of the brain.

The son of Jesse and Eveline Miller, Dr. Miller was born November 8, 1876, in Galena, Ohio. He attended Otterbein University in Westerville, Ohio, and in 1910 took his medical degree from Starling-Ohio Medical College (now Ohio State University College of Medicine). He came to Texas, locating first in Falfurrias and then moving in 1918 to San Antonio, where he was in practice until his death.

DR. JOHN BURR MILLER

Dr. Miller was a member of the State Medical Association and American Medical Assotion through Kleberg County Medical Society and then through Bexar County Medical Society. From 1910 until 1918 he was local physician and surgeon for the San Antonio and Aransas Pass Railroad. He was a member of the Christian Church, the Masonic Order, Scottish Rite, Shrine, Sons of Herman, and Jesters.

Survivors include his wife, the former Miss Maude L. Waterman, whom Dr. Miller married in Payette, Idaho, December 24, 1898; one daughter, Mrs. William Turnbull, and one son, Dr. John B. Miller, Jr., both of San Antonio; one sister, Mrs. Lillie Morris, Madison, Ala.; and two brothers, Otto Miller, Monte Vista, Colo., and Arthur Miller, Westerville, Ohio.

Dr. Edwin Ball Hailey, Conroe, Texas, died at his home July 16, 1946.

Dr. Hailey, son of Samuel K. and Mary Sue (Ball) Hailey, was born December 25, 1905, in Conroe and attended high school there. His academic education was received from the University of Texas, Austin, where he took a bachelor of science degree in 1928, and his medical education from the University of Texas Medical Branch, Galveston, where he was graduated in 1932. He served a one year internship at John Sealy Hospital, Galveston, and then returned to Conroe to practice, remaining there until his death.

Throughout his professional career Dr. Hailey was a member of the State Medical Association and American Medical Association through Montgomery County Medical Society. He was president of the county society from 1935 until his death. He was a member of the Methodist Church, Masonic Lodge, Rotary Club, Phi Kappa Alpha, and Alpha Mu Pi Omega Medical fraternity.

On July 15, 1933, in Galveston, Dr. Hailey married Miss Catherine Lucile Weaver, who survives. Also surviving are two sons, David Edwin Hailey and Richard Lee Hailey; his parents, Mr. and Mrs. S. K. Hailey; two sisters, Mrs. J. M. Coleman and Mrs. P. D. Evans; and one brother, Samuel K. Hailey, Jr., all of Conroe.

Dr. Travis M. Harrell, Corpus Christi, Texas, died February 22, 1946.

The son of Frank and Mollie Harrell, Dr. Harrell was born February 8, 1864, at San Saba. When he was 7 years old, he moved with his parents to Williamson County, and attended school at Round Rock. He went to medical school in Baltimore and then in Louisville, Ky., receiving his degree from the University of Louisville School of Medicine in 1894. Dr. Harrell first practiced medicine at Hunter, Texas then in Round Rock, and after 1922 in Corpus Christi.

DR. TRAVIS M. HARRELL

Throughout his professional career Dr. Harrell was a member of the State Medical Association and the American Medical Association, through Williamson County Medical Society, and then through Nueces County Medical Society when he moved to Corpus Christi. He was a member of the Texas Railway and Traumatic Surgical Association and its first vice-president at the time of his death. He was also a member of Woodmen of the World. He was a member of the Methodist Church and made extensive contributions to its causes, donating the Memorial Chapel to the Methodist Orphanage at Waco, an endowment fund to Southwestern Universiy at Georgetown, and a pipe organ to the Methodist Church at Corpus Christi.

On October 31, 1888, Dr. Harrell married Miss Maggie Faubion, of Leander, and to this union was born a son, Presley Harrell. Both son and wife preceded Dr. Harrell in death, Mrs. Harrell dying May 27, 1939. Dr. Harrell married Mrs. Vira Douglas on July 12, 1940. She; two stepsons, Ramey Douglas and Otho Douglas, both of Corpus Christi; and four sisters, Mrs. Ardella McFarlan, Austin; Miss Fannie Harrell, Round Rock; Mrs. May Sullivan, Houston; and Mrs. Cloie Kilgore, Yakima, Wash., survive.

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Vol. XLII **October, 1946** **No. 6**

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION AND PUBLIC HEALTH IN TEXAS

Our "Must" Legislative Program for next year has been rather definitely determined. So, also has our legislative program in general. However, the must phase of the program only will be discussed at this time. There may be changes in the rest of the program before long, and all of the measures in which we are interested may be discussed later on.

It should be understood that when the State Medical Association goes to the Legislature with a legislative program, it will expect to either carry the ball or run interference. It will carry the ball for those measures which it considers strictly and directly, if not exclusively, the concern of the medical profession of Texas as represented by the State Medical Association. There are a number of organizations in the State concerned with the health of our people, and anxious to do something in a legislative way to better such conditions, such as, for instance, the Texas Tuberculosis Association, the State Board of Health, and the sponsors of the Dallas Psychopathic Hospital, to name several, and we have approved the legislative programs of these organizations, and even the bills that they will introduce. We will not carry the ball for them, but we will run interference, so long as by so doing we do not mess up our own game.

While not strictly a matter of public health legislation, the pending Constitutional Amendment which requires that motor vehicle registration fees and gasoline taxes be used exclusively for road construction purposes, except the one-fourth of the gasoline tax allotted to the available school fund, has been approved by our Executive Council. It is clear that practicing physicians, particularly those in rural areas, are directly interested in good roads and anxious that tax money coming in from gasoline, vehicle licensure and the like, be devoted to the development of good roads, except that portion allotted to the available school fund.

It is clear that if all of the organizations sponsoring public health measures at the same time carry the ball and run interference for each other, wires will get crossed and confusion will obtain. Not only that, but opposition to any of the measures concerned will have a much better opportunity to swap out on us than if each organization manages its own legislative strategy and tactics.

We call attention at this time to the proposed Basic Science Bill and Revision to the Medical Practice Act—the "must" legislative program of the State Medical Association for the forthcoming session of the State Legislature. A brief discussion of the two bills follows:

The Basic Science bill and the bill Revising the Medical Practice Act, are necessarily companion pieces and should be considered together. They will be introduced separately, the Basic Science bill first, and the Medical Practice Act Revision bill almost immediately thereafter. If the Basic Science bill is not enacted into law, the proposed revision of the Medical Practice Act would hardly suffice on its own, because of the omission therefrom of the basic science subjects. How-

ever, if the Basic Science bill is passed, and the Medical Practice Act Revision measure not enacted into law, there will be some confusion, but the Basic Science law can be used in connection with the present Medical Practice Act. There will be duplication in the matter of examinations in that the basic science subjects will still be included in the Medical Practice Act. These and other conflicting parts of the two measures can, of course, be adjusted later on, perhaps in a subsequent Legislature.

It is important to remember in connection with the proposed revamping of our medical licensure procedures, that the Constitution of the State of Texas will not permit setting up separate standards for the separate schools of medicine, for the reason that thus discrimination as between schools will certainly be established. It is this constitutional provision that has saved the public health of Texas the imposition of cult licensure without educational safeguards. The question might well be asked, then, how will the proposed procedure be made to accord with the State Constitution. It is proposed that an examination in the basic sciences by a Board of educators who are in no way connected with the practice of medicine, be exacted of all who would practice any branch of the healing art, and that examinations then be given by those branches of the healing art which desire to perpetuate their scope, limitations and practices, the examinations in each instance to be given by examining boards composed of practitioners of the branch of the healing art concerned. Thus it would seem that the Basic Science Law, applied to all alike, sets up a standard which cannot be construed as in any way discriminating as between the so-called schools of medicine. It would seem that the Practice Act of each of the schools of medicine, or branches of the healing art, will be setting up standards for their own use, in their own method of practice, and in accordance with the teachings of their own colleges. It is believed that this procedure is not in contravention of the much discussed constitutional requirement that in the enactment of laws controlling the practice of medicine there shall be no discrimination as between schools of medicine.

The Basic Science Bill now believed to be ready for introduction in the Legislature, is a revision in quite a few important particulars of the Basic Science bill which was introduced in the last session of the Legislature and which failed of passage. While these changes are important, none of them are basic. They merely tend to make a finished product of the measure, and it is believed that it is now as nearly suited to our needs as it can be made. To begin with, the first version of this measure included the best features of the several existing basic science laws in the country, fitted together to meet our requirements. The changes that have been made have been carefully considered from the legal, medical and public health angles, and all implications and ramifications followed through to their final application. The new bill has been put in type in the style and form used by the Legislature, with numbered pages and numbered lines. Copies of the bill in ample numbers will be furnished county society legislative committees, and others interested in the passage of the measure, in order that suggestions may be made as to changes, line by line. The State Association Legislative Committee will give careful consideration to all such suggestions. County society legislative committees will see that their respective legislators receive copies of the bill, and that they understand it. Thus no member of the Legislature will go to Austin with the wrong conception of what their doctors want done with respect to this part of the problem of medical licensure.

It is hardly feasible to give an analysis of the Basic Science bill here, but a few facts should be pointed out at this time. No person will be permitted to take an examination for a license to practice any healing art without receiving from the Basic Science Board a certificate of proficiency in six so-called basic sciences, namely, anatomy, physiology, chemistry, bacteriology, pathology, and hygiene and public health.

The healing art includes any system, treatment, operation, diagnosis, prescription or practice for the ascertainment, cure, relief, palliation, adjustment or correction of any human disease, ailment, deformity, injury or unhealthy or abnormal physical or mental condition.

The Board of Examiners in the Basic Sciences will consist of six members appointed by the Governor, and selected because of their knowledge of the basic sciences named in the act. Each member of the board will be a professor, or an assistant or associate professor on the faculty of one of the first class universities or colleges in the State, no member of which shall be actively engaged in the practice of the healing art or any branch thereof.

The members of the Board will be paid a per diem of $10.00. The fee for the examination will be $15.00, with a $10.00 fee for reexamination within a period of twelve months. The per diem and other expenses of the Board will be paid from these fees.

The examinee must be a citizen of the

United States; not less than nineteen years of age; of good moral character, and a graduate of an accredited High School.

The Basic Science Board will recognize certificates from basic science boards of other states having the same standards as ours.

Any person who practices the healing art or any branch thereof without having obtained a valid certificate from the Basic science Board may be fined or imprisoned, or both, not for violating the Medical Practice Act, but for violating the Basic Science Act. No Board of Examiners may examine any person who does not hold a certificate of proficiency in the basic sciences, issued by the Basic Science Board.

No provision of the Basic Science Act may be construed as repealing any statutory provision in force at the time of its passage with reference to the requirements governing the issuance of licenses to practice the healing art.

The bill carries what is believed to be a very effective injunction feature.

The New Medical Practice Act, according to the bill approved by the Legislative Committee and the Executive Council, and now ready for introduction in the Legislature will, in effect, be the Medical Practice Act for the unlimited practice of medicine. The idea is that each branch of the healing art which desires to regulate its own practices will set up a Practice Act accordingly, regulating its scope and limitations. Whether any particular branch of the healing art will be recognized by the State, and allowed to set up its own rules and regulations will, and must be the responsibility of the Legislature. Manifestly, and it goes without the saying, a Practice Act for a limited branch of the healing art which would give the practitioners of that branch unlimited privileges in practice perhaps not taught in that school, would be an infringement on the unlimited Medical Practice Act, and certainly not at all logical. Whether or not anybody does anything about this phase of the problem remains to be seen. The best the Legislature can do is to set up laws which are consistent with a general plan which is fully protective of the public health as it relates to the practice of medicine or the healing arts, and provide suitable penalties for violation of such laws. It is hoped that at least this will happen.

The changes in the present Medical Practice Act are many and important. We cannot enumerate all of them, or discuss any of them at length.

The definition of the practice of medicine, which has withstood attack since the present Medical Practice Act was enacted in 1907, will be changed so as to add "to diagnose or offer to diagnose disease" in addition to treat or offer to treat the same.

The Board of Medical Examiners shall consist of six members rather than twelve, and all of them graduates in medicine from Class A Medical Colleges.

The Board will be required to equip and maintain a suitable office of record, and employ a Secretary at a salary of not less than $2,400.00 per year, with such clerical assistance as may be necessary. The expenses of the office and of the clerical staff will be paid from the fees received by the Board in examining applicants and issuing reciprocity licenses.

The present Annual Registration Law will be repealed, and there will be set up instead, in the office of the Secretary of the Board, a "Register," which will be prima facie evidence of all matters contained therein. The Secretary of the Board will file with the Secretary of State, for permanent record, a certified copy of this Register once each year. It is hoped and expected that this procedure will compensate for the present Annual Registration law, which, as stated above, will be repealed.

The same educational standards and safeguards existing in the present Medical Practice Act are perpetuated in the new version.

Applicants to be eligible for examination must be citizens of the United States, of good moral character, and must have completed the same courses of study called for in the present Medical Practice Act, and must hold certificates from the Texas Basic Science Board. The definition of a reputable medical school is the same as before, and must be classified by the Board as at the present time. In making its classification, the Board may act upon any evidence it believes to be satisfactory, and may appoint agents to determine any necessary facts or information.

The exemptions carried by the present Medical Practice Act will be named in the new Act, plus practitioners of branches of the healing art known at the present time to be interested in securing Practice Acts of their own, including the osteopathic and chiropractic groups. As additional Practice Acts are set up, it will be necessary to include in all of them exemptions of all of the others.

Reciprocity is provided for as at the present time, except that certificates from the Texas Basic Science Board are also required.

As at the present time, the Board may refuse to issue licenses to persons known to have procured their medical credentials

illegally or fraudulently; any who have been convicted of a crime of the grade of felony, or any of several crimes named in the act; drug addicts; any guilt of grossly unprofessional or dishonorable conduct; any who have violated or attempted to violate the provisions of the Medical Practice Act; or of advertising of a character which may mislead; advertising professional superiority; purchase, sale or barter or use of any medical degree, license, certificate, diploma, etc., incident to an application to the State Board of Medical Examiners for license to practice medicine; altering, with fraudulent intent, any medical license, certificate or diploma; use of any such fraudulent credentials; the impersonation of another person in any examination required by the Medical Practice Act; the impersonation of a licensed practitioner, or employing directly, or indirectly, persons whose licenses to practice medicine have been suspended or who have been convicted of the unlawful practice of medicine in the State of Texas or elsewhere.

The same injunction feature carried by the Basic Science measure has been written into the Medical Practice Act measure. It is in line with the injunction features of the present Medical Practice Act.

The bill carrying revision of the Medical Practice Act will be printed in the style used in the Legislature, with numbered pages and numbered lines, and circulated as in the case of the Basic Science bill, already explained.

County Medical Society Adjudication Committees.—At a meeting of the Executive Council of the State Medical Association held September 29, in Fort Worth, referred to elsewhere in these colums, approval was voted by the Council of recommendations contained in a report from the Public Relations Committee, that county medical societies establish "adjudication" committees.

For the purpose of record and explanation, brief reference to the history or beginning of the idea that inaugurated this movement will be made. About six years ago, Harris County Medical Society decided to establish an adjudication committee, the functions of which would be to settle disagreements between members of that society and insurance carriers in industrial compensation cases. In order to give authority to the committee and its functions, the following amendment was incorporated in the by-laws of that society:

"An adjudication committee to supervise industrial compensation practice shall be elected at the annual business meeting. This committee shall consist of seven members, six to be elected and the seventh to be the president of the society ex-officio. Two members shall be elected each year. These terms shall be for three years. The duties of this committee shall be to adjudicate disputed bills between insurance companies and members to determine and to set fair fees for industrial practice in Harris County; to investigate industrial compensation contracts which are alleged to be unfair; to investigate and report to the board of censors allegations of solicitations of practice; to investigate medical testimony given in cases involving industrial injuries; and to establish such rules of conduct as the committee determines are necessary to carry on industrial compensation practice, according to the laws of the State of Texas and the principles and ethics of the American Medical Association."

During the first two years the Committee was kept busy settling disputes which came within the purview of its functions. In subsequent years, because of its excellent record of handling such cases, standards were determined and recognized, and there was little for the committee to do in connection with industrial compensation cases. Visualizing the potential value of such committee, its functions of late have been increased by that society so that it now serves a broader purpose as a public relations committee. Four additional members representing various medical specialties have been added to its personnel. The committee now serves as an arbiter in all cases in which complaints have been made by patients that they have been charged exorbitant fees for medical services or have been dealt with unfairly in any way by their physicians. The existence of the committee and its purposes have been widely publicized by the committee through the lay press of Harris County, which has been enthusiastic in its appreciation of this public service on the part of Harris County Medical Society. The good will engendered by such activity is readily apparent.

When this activity came to the attention of the Public Relations Committee of the State Medical Association, chairman Dr. Minter assigned to Dr. J. E. Hogan, member of the committee, a study of its provisions and experience. Following a report by Dr. Hogan, the Public Relations Committee recommended to the Executive Council that other county medical societies of the Association be urged to consider the advisability of establishing similar committees. The Executive Council warmly approved the suggestion.

For the smaller societies the existing Committee on Legislation and Public Relations required by the By-Laws of the State Medical Association, might well assume the functions outlined here for adjudication committees.

Whether or not county medical societies shall establish such committees will, according to the action so far taken, be purely a voluntary matter. The experience of the Harris County Medical Society indicates that such committees may serve a most useful purpose,

and the services rendered in the interest of the patient have been highly appreciated by the public.

The Public Relations Committee of the State Medical Association is to be commended for its excellent suggestion, and it is hoped that county medical societies will establish adjudication committees, as recommended.

County Medical Society Preceptorship Committees.—Reference has been made elsewhere in these columns to action taken by the Executive Council of the State Medical Association at a meeting September 29. The minutes of that meeting are published in this number of the JOURNAL (page 389) and should be read by every member of the Association.

One of the most unique proposals considered by the Executive Council was contained in a report prepared by and presented for the Public Relations Committee, by Dr. George Schenewerk, a member of the committee, in which it was recommended that county medical societies establish committees on preceptorship. Briefly stated, the functions of such committees would be to instruct applicants for membership regarding their responsibilities to the organization and the public before they are given the privileges of membership. It was proposed that such instruction be given in a series of six lectures, one each month, by members of the Society especially qualified. The broad subjects suggested for this series of lectures, with their subdivisions, were as follows:

1. History of Medicine and Medical Ethics
   - a. World
   - b. American
   - c. The American Medical Association
   - d. The State Medical Association
   - e. Component County Societies

II. Medical Education
   - a. Premedical
   - b. Medical
   - c. Hospital
   - d. Postgraduate
   - e. Periodicals and Medical Publications
   - f. Membership in Medical Organizations

III. Public Relations
   - a. Authority
   - b. Responsibility
   - c. Methods of Conduct
   - d. Probable contact groups

IV. Medical Economics
   - a. Location (urban - rural)
   - b. Type of building (office)
   - c. Rent or Purchase
   - d. Establishing an office
   - e. Individual or group practice
   - f. Bookkeeping and accounting
   - g. How to build a practice
   - h. National status in relation to other groups
   - i. The Armed Forces
   - j. The Veterans Administration

V. The Law
   - a. Malpractice
   - b. Status of the cults
   - c. Public Health Department
   - d. Police Department
   - e. Conduct in Court
   - f. Internal Revenue
   - g. Traffic Safety
   - h. Coroners Office

VI. Insurance and Banking
   - a. Social Security
   - b. Medical and Hospital Insurance
   - c. Workmen's Compensation
   - d. Types of contract and amount the individual physician should have
   - e. Investments for the physician

The intent of such instruction for candidates for membership in a county medical society is clear. A member well oriented in his responsibilities to the medical organization of which he is a part and in his responsibilities to the public as a physician will be a far more valuable member than one who is not. Certain fraternal organizations have long used such lectures for their candidates for membership. Certain churches require that their members receive instruction before they can be confirmed.

The debate by members of the Executive Council on the proposal of preceptorship committees for county medical societies brought out the point that any factors which might be interpreted as interfering with membership would violate the organic law of the State Medical Association and American Medical Association.

The Council voted 10 to 8 in approval of the establishment of county medical society preceptorship committees, provided their establishment is placed on a voluntary basis, and provided, further, that the lectures for prospective members also be voluntary rather than compulsory.

It is doubtful if much will be done about the matter under the decision of the Council. Two objections which might well be raised to the proposal is that the subjects to be covered are too extensive for the purpose desired, but the Committee in presenting the matter readily agreed that the subjects would, of course, be changed or adapted to the wishes of any county medical society. The second objection is that six months is a rather long waiting period, and the six lectures might easily be given in six weeks instead of six months. The shorter period of instruction, it is believed, would be much more readily accepted by those who would insist that the longer period of six months would tend to interfere with physicians applying for membership.

There is unquestioned merit in any procedure which will make better informed members of county medical societies, and it is believed that if a county medical society utilizes the proposal advanced here in a practical manner, new members will be highly appreciative of the instruction offered rather than

resentful. It is deserving of trial. It has been successfully used by the Los Angeles County Medical Society, California, over an extended period of time.

The Southern Medical Association will hold its fortieth annual meeting November 4-7, 1946, at Miami, Florida. General headquarters, including place of registration, information, motion pictures, scientific, hobby and technical exhibits, will be in the Municipal Auditorium in Bayfront Park on Biscayne Boulevard. Some of the scientific sessions will also be held in the Municipal Auditorium, and the remainder in bayfront hotels within five blocks. All of the sessions may be reached easily, walking from any hotels, including those downtown.

The afternoon of Monday, November 4, and morning of Tuesday, November 5, have been designated as "Miami Day," and a clinical program representing every specialty will be presented by the local profession. Beginning Tuesday afternoon, November 5, the twenty-one scientific sections of the Southern Medical Association, the Southern Branch of the American Public Health Association; Southern Chapter, American College of Chest Physicians; the American Society of Tropical Medicine and the National Malaria Committee, will each begin their several sessions concurrently, decision having been made by the Executive Committee to continue the war time streamlined type of program for one more year.

The scientific programs presented at meetings of the Southern Medical Association are of exceptionally high order, as is well known by all Texas physicians who have attended these meetings.

Miami is an interesting and delightful place to visit at any season of the year, but particularly during the month of November. Its recreational opportunities are too well known to be embellished here.

Any member in good standing in his State Medical Association is eligible to become a member of the Southern Medical Association and can accomplish such membership and register at this meeting by paying the annual dues of $4.00, provided he has his State Medical Association membership card with him. For this amount he will also receive the *Southern Medical Journal,* one of the best medical publications in this country. For those of our members who wish to combine a trip offering superb recreational opportunities, outstanding scientific pabulum, and fellowship of the highest order, the meeting of the Southern Medical Association at Miami is heartily recommended. Hotel reservations should be made and confirmed to the hotel of choice. If difficulty is experienced, the Hotels Committee of the Southern Medical Association in the Miami Chamber of Commerce, Shoreham Arcade, Miami, Florida, will gladly be of service.

The Oklahoma City Clinical Society announces its sixteenth annual fall clinical conference October 28-31, in Oklahoma City, with headquarters at the Oklahoma Biltmore Hotel. A distinguished group of guest speakers, headed by Dr. Harrison H. Shoulders, Nashville, Tennessee, President of the American Medical Association, has been secured for the occasion. This list with the positions of responsibility and preferment of each lecturer is published on advertising page 14 of this number of the JOURNAL, which should be referred to by any member of our Association contemplating attendance.

The Conference will be featured by general assemblies, postgraduate courses, roundtable luncheons and symposia, the scientific program utilizing to the greatest advantage the teaching abilities of the guest lecturers.

Social features and entertainment for the wives of visiting physicians are all that could be desired. For registrants at the Conference the clinic dinner and annual supper and smoker are events looked to with pleasure from year to year. For both registrants and visiting ladies the annual party given by the Oklahoma City Chamber of Commerce in the second evening is a particularly delightful occasion. In addition, a well rounded program of entertainment has been planned especially for the visiting ladies by the Women's Auxiliary of the Oklahoma County Medical Society.

There will be, also, the usual collection of informative technical exhibits which add much to any medical meeting.

A registration fee of $10.00 covers all features of the Conference. For those planning to attend, hotel reservations should be made promptly. If assistance is needed, the Executive Secretary of the Conference, 512 Medical Arts Building, Oklahoma City, will be glad to serve.

Texas physicians who have attended this conference are warm in their praise of its scope and conduct, and they are well versed in what a postgraduate clinical conference should be from experience in their own state. No physician will have cause to regret four days spent in the intensive postgraduate study offered under conditions that are attractive and inspiring.

Good Roads Constitutional Amendment.—A proposed amendment to the Texas Constitution which would prohibit the diversion

of gasoline tax funds to purposes other than good highways met the favor of the Legislative Committee of the State Medical Association of Texas when it was considered at a meeting of the Committee in Fort Worth on September 28. The amendment will be voted on in the November general election.

According to the amendment, which was adopted by the last Legislature, subject to ratification by Texas voters, the present allocation of funds from motor fuel taxes and motor vehicle registration fees would remain unchanged, with one-fourth of the net revenue from the fuel tax continuing to go into the free school fund, one-fourth to the county and road district highway fund to pay principal and interest on bonds issued years ago to finance the construction of state highways, one-half to the state highway fund, and all registration fees to the state highway fund and the road and bridge funds of the respective counties.

Advocates of the amendment point out that diversion of funds from taxes on road users has been gradually increasing for several years, reaching the sum of $200,000,000 throughout the United States in 1941, thereby seriously affecting the highway systems of the states in which such diversion occurred. The amendment would merely block similar diversion of funds in Texas in the future, thus continuing the fair practice of taxing those who use the roads to pay for their construction and maintenance. The importance to the economic welfare of developing an adequate system of primary highways with suitable routes through cities and necessary feeder roads—farm to market roads—is generally recognized. Cognizance of the value of such a highway system was taken by the Congress and the President in enacting a Federal Aid Highway Act in 1944, under the provisions of which during the first three years immediately following the official cessation of war, $500,000,000 of federal money will become available for highway construction in the various states, provided the states match the funds dollar for dollar. It is believed that such a project will provide economically worth-while work for thousands of returning war veterans. The proposed program in Texas for the three years will cost $172,593,600, of which half will be furnished by the federal government and half must be provided by the state. Under the program, 2 per cent of all rural dwellings will be brought within one mile of a paved road and 74 per cent within two miles. Paved roads will therefore be made available for most school buses, thus increasing the efficiency of consolidated rural educational systems. In order to participate in this program and to plan wisely for the future of Texas highways, a source of funds must be guaranteed. The proposed amendment to the Constitution would assure a supply of funds which would allow efficient long-time planning and financing.

The Legislative Committee of the State Medical Association recognizes the fact noted in the preceding paragraphs. Members of the Committee are also aware that good roads mean physicians can more readily reach patients in rural areas, and patients themselves can more easily seek proper medical attention and hospital care in urban centers, thus providing the background for better health among the residents of sparsely populated sections. The Committee therefore believes that members of the State Medical Association should support the good roads amendment and vote to ratify it when it is submitted to the electorate November 5.

Members of the State Medical Association are urged to coöperate with other farsighted groups throughout Texas which have already pledged themselves to support the good roads amendment. Passage of the amendment will be beneficial to a great many Texans, and will specifically serve the cause of better health.

CURRENT EDITORIAL COMMENT*

Penicillin by Prescription?—*The New England Journal of Medicine*[1] reports that the Department of Health of the City of New York has added to its Sanitary Code a section which ". . . restricts the sale of preparations containing penicillin or other antibiotic drugs to persons presenting a written prescription of a physician, dentist, podiatrist or veterinarian," except for such preparations which the department may specifically exempt. This is an action which deserves careful consideration by the health agencies of other communities, since the restriction is based upon sound and commendable principles.

Only infrequently is the use of penicillin followed by undesirable reactions, and certainly the incidence of such reactions alone would not justify restrictions upon its use. It is recognized, however, that inadequate dosage of the drug may readily lead to suppression of immediate symptoms without affecting a cure. This problem is of especial importance in cases of mixed infections. An additional problem is posed by the possibility

*This department of the JOURNAL presents editorial comments on current items pertaining to the science, art and practice of medicine, contributed by members of the State Medical Association and scientists closely associated with the medical profession of Texas. Invitation is hereby extended to any member of the State Medical Association of Texas to submit such discussions for this department. The discussions should not be more than 500 words in length.

of the development of penicillin-fast pathogens.

As long as the use of penicillin was restricted to parenteral modes of administration, the dangers inherent in its use were minimal, since competent medical supervision was almost automatically assured. With the appearance on the open market of tablets, troches, and ointments containing the antibiotic, the possibilties for inadequate self-treatment are tremendously enlarged, and the question of restricting its indiscriminate use becomes a vital one.

The public is sufficiently aware of the dangers of the unsupervised use of drugs which are potentially toxic. It may be a much more difficult task to convince people of the necessity for control of a drug which has been widely advertised as being almost ideal in its lack of toxicity. The major share of the educational burden must be assumed by groups and individuals associated with the medical profession.

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NEUROPSYCHIATRIC PROBLEMS OF RETURNING SERVICEMEN

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The neuropsychiatric problems of veterans constitute the major issue currently before the Department of Medicine and Surgery of the Veterans Administration. As of March 21, 1945,[2] the Veterans Administration had 101 hospitals containing 85,311 beds under its jurisdiction. Thirty-three, or approximately one-third of the hospitals, are straight neuropsychiatric hospitals and contain 50,551 beds. On the same date, 74,785 beneficiaries were receiving treatment in these hospitals of whom 44,400 were veterans with neuropsychiatric illnesses. Figures are not available for the number of veterans receiving outpatient care. However, roughly 60 per cent of the Veterans Administration present facilities and patients are neuropsychiatric in type. Actually twenty years had elapsed after World War I before the number of neuropsychiatric beneficiaries grew to exceed those of all other kinds. Some of these veterans add to the present patient load, but the fact that neuropsychiatric veterans did exceed all medical and surgical patients even as World War II ended does merit serious consideration.

The care of these patients thrust a tremendous burden upon an organization ill-prepared to meet it. It should be remembered that hospital care is but one of the functions of the Veterans Administration. Prior to the appointment of General Omar N. Bradley, in 1945, to the position of Administrator of Veterans Affairs, political machinations, administrative inefficiency, and inadequate appropriations created many deficiencies in the medical care provided for veterans. Serious shortages existed in beds, clinics, personnel, and planning—even plans delineating a treatment program were lacking.

The present administrator is trying to correct these inefficiencies, and now unlimited appropriations are available for expansion. Foremost, he should receive the support of everyone in his efforts to keep veterans' affairs out of politics. New hospitals and mental hygiene clinics are to be located near medical centers in order to secure the service of recognized specialists. Similarly a campaign is now under way to obtain a sufficient number of competent doctors and adjunct medical personnel to provide veterans with the best available medical attention. An influx of capable administrators whose energetic planning led to expanded facilities and acquisition of better personnel has enabled the Veterans Administration to promulgate specific methods by which all eligible veterans can receive treatment. This information is now available to the veterans, their families, and physicians. One of the purposes of this paper is to outline the various methods for neuropsychiatric treatment provided by the Veterans Administration since everyone seems confused about ways to secure the necessary treatment for veterans.

Before discussing these plans, it is of interest to know why the Veterans Administration anticipated 77,450 neuropsychiatric hospital patients by 1950. This will almost double the present number of neuropsychiatric beneficiaries in the next five years. From what large reservoir will these patients be drawn and what factors are responsible for the occurrence of such delayed, incapacitating illnesses? To begin with, the anticipated patients will be derived mainly from the following categories: first, those patients who were granted medical discharges from the Army because of neuropsychiatric disorders on a Certificate of Disability for Discharge; second, veterans who had psychiatric illnesses before or during their military service but did perform duty and were discharged through nonmedical channels (points, and so

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forth); third, those veterans with a negative history for a psychiatric illness, but who may be expected to develop disabling psychiatric conditions following discharge from the service. Of course, the whims of Congress are unpredictable, and new laws may provide unanticipated sources for more patients.

In regard to the first category, statistics recently released by the Surgeon General's Office, United States Army,[1] while incomplete, show that 320,000 veterans were given neuropsychiatric discharges in the period from January 1, 1942, through June 30, 1945. Obviously, the majority of these 320,000 veterans have been able to settle themselves in civilian life or else they are not recipients of care by the Veterans Administration. To a great extent this ability for readjustment will depend on the type of neuropsychiatric disorder for which the serviceman was given a discharge. The same statistics indicate that 70 per cent were discharged with the diagnosis of psychoneurosis, 15 per cent had psychoses, 11 per cent had neurological disorders or epilepsy, and the unclassified psychiatric conditions made up the remaining 4 per cent. In one follow-up series of men discharged from the Army for psychoneurosis, 86 per cent were gainfully employed, and this is to be expected as psychoneurosis is a recoverable disorder. In another study of veterans discharged with a diagnosis of psychosis, 60 per cent had readjusted in civilian life and were reemployed.

An unknown number of veterans either had psychiatric illnesses prior to military service or else developed an illness in the service, but many were able to adjust to the Army and were eventually discharged through the point system. For example, in addition to the previously mentioned 320,000 servicemen who were given medical discharges, approximately 700,000 more servicemen were admitted to Army hospitals with neuropsychiatric conditions, but later were returned to a duty status. Likewise, all large training centers had mental hygiene clinics where unnumbered thousands of servicemen received psychiatric treatment and were able to continue effectively in the service. Statistics are not available from the other military services, but unofficial figures are reported as comparable in proportion to the numbers involved. Roughly 10,000,000 servicemen have now been discharged by the point system after performing satisfactory military service. The vast majority of these veterans had stable, well-adjusted personalities prior to military service, and experienced little or no emotional disturbances while in uniform. However, many servicemen who received nonmedical discharges are now consulting physicians because of neuropsychiatric complaints.

Next, let us consider the factors which might keep veterans in each of these categories from readjusting to civilian life or else could cause them to develop personality difficulties after a period of apparent adjustment. It must be assumed that the exigencies of military life exerted a profound and perhaps detrimental influence on the personality make-up of many servicemen. None the less, the ability to readjust to civilian life and maintain good mental health is dependent upon two other significant factors. The most important quality is the degree of personality integration and the basic emotional stability existent in the veteran's make-up, while the economic, social, and interpersonal relationships within the veteran's environment constitute a second factor which can be both controlled and modified.

The stable, well-adjusted veteran with a minimum of basic anxiety can make the transition from civilian to soldier and back to civilian status again without much emotional upheaval. The less stable personality and the chronically maladjusted person may develop an incapacitating psychiatric illness unless a fairly ideal environment is created for him. Medical authorities realized that it was impossible to give individual counseling or psychiatric guidance to all returning veterans. Consequently, efforts were made to improve the veteran's environment through an educational campaign designed to reach the veteran's family, his friends, his employer, and other persons who could facilitate resettlement in civilian life. The National Committee for Mental Hygiene and similar organizations did an excellent job of propagandizing the public on this matter. Rennie and Woodward's[4] expressions summarized the consensus of authoritative opinion on readjustment advice: "Friends and relatives are advised to listen well when he wants to talk, but not to pry; to face the reality of his disability without ignoring or magnifying it; to treat him as an essentially normal, competent person, not as an invalid; to allow him time and freedom in becoming acquainted with the old environment and in reestablishing old contacts; to render assistance in returning to work." These authors stressed the importance of securing professional help where it is needed.

These efforts are to be commended. From a practical standpoint, the average veteran can work out his own problems if given freedom of action and the opportunity to create an environment similar to the one he had been fighting to preserve. Unfortunately, instead of peace and security, world conditions

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are now more chaotic than ever. The renewed threat of war, mounting unemployment, delayed production through continued strikes by already unpopular labor unions, the inability to find a house in which to live or a suit to wear, or the apparently selfish motives of some persons who profited by remaining at home are some of the circumstances which tend to make the veteran feel that his military service was unappreciated and that he had been "played for a sucker." Where such beliefs do exist, it may aggravate the pent-up hostility and resentment which many veterans already hold toward the military service. These further frustrations are sufficient to mobilize more anxiety and create greater tension either to reactivate a previous illness or else produce a new one.

VETERANS ADMINISTRATION PROGRAM FOR NEUROPSYCHIATRIC CARE

The following procedures on neuropsychiatric care for veterans in Texas were submitted by the Manager, Veterans Administration, Waco,[3] and are presented in outline form:

A. Methods of admission to hospitals.
   I. Emergency admission of patients to Veterans Administration hospitals.
      a. Any eligible veteran who presents a medical emergency, needing immediate hospitalization, is given preference for admission.
         1. Eligibility—any wartime veteran honorably discharged irregardless of service connection. Veterans of peacetime service are eligible only for service-connected disability. Even veterans discharged "without honor" are entitled to emergency treatment while eligibility is being reviewed. Dishonorably discharged veterans are never entitled to treatment.
      b. Methods of emergency admission.
         1. Call the Admitting Officer, Veterans Administration, Waco, either day or night. Request for admission may be made by the veteran, a member of the family, the physician, the local Contact Officer of the Veterans Administration, the American Red Cross, or an ex-service organization.
         2. Permission for emergency admission can be granted by the responsible officer on duty.
         3. Where transportation reimbursement is desired, it can be granted at the time of the telephone conversation.
         4. A court order for confinement is not required for admission.
   II. Emergency admission of patients to contract hospitals.
      a. Any veteran of war or peace who constitutes an emergency where the disability requiring hospitalization is service-connected; or any woman veteran whether or not the disability is service-connected who constitutes an emergency, may be hospitalized in a private hospital if the veteran cannot be safely moved or if a Veterans Administration hospital is not readily available. Immediately contact either the nearest Regional Office or Manager, Veterans Administration, Waco.
   III. Acutely ill veterans who present themselves at Army or Navy specialized psychiatric hospitals are accepted as emergency admissions for later transfer to the Veterans Administration.
   IV. Routine methods for hospitalization of all neuropsychiatric patients.
      a. Eligibility for admission is as defined above.
         1. Emergency conditions receive first consideration.
         2. Veterans with service-connected disabilities receive second consideration.
         3. Next come nonservice-connected disabilities for which bed space is very inadequate at this time. Veterans must make a sworn statement that they are unable to defray expenses of private medical treatment.
      b. Method for routine admission.
         1. Secure Veterans Administration Form P-10 from local Contact Officer, who will assist the veteran in filling out page 1.
         2. Physician should state clearly and specifically the positive findings on the Doctor's Certificate to facilitate admission.
         3. Request for transportation should be included where desired.
B. Existing outpatient service for veterans.
   I. Outpatient treatment is provided for any disease or injury that is service-connected and causes discharge from service or for any condition becoming worse after discharge if adjudicated as aggravated by service.
   II. Examinations are conducted for veterans filing claim for pensions.
   III. "Point discharges" are entitled to outpatient treatment if the Chief Medical Officer believes there was a reasonable probability that the veteran's disability was incurred in or aggravated by service.
   IV. The Chief of Outpatient Service, Veterans Administration, Waco, or the appropriate Regional Office can designate a private physician to treat a veteran for a specified number of times at a specified fee. Similar arrangements can be made to conduct neuropsychiatric examinations for a fee of $7.50 each.
C. Mental Hygiene Clinics (to be established in Texas).
   I. Clinics at Regional Offices for active therapy (pending).
   II. Contract Civilian Clinics—none presently operating in Texas.
D. "Family Care" Plan.
   I. Veterans are placed in selected homes by Manager, Veterans Hospital, Waco, or Regional Office. A sum of $10 per week is paid for lodging of veteran.
E. Proposed Plan for Care by Private Physicians and in Private Hospitals.
   I. The Veterans Administration has a method of providing treatment by private physicians and in private hospitals to veterans with service-connected disabilities. To do this, arrangements must be made by state medical societies with the Veterans Administration. Seven states now have contracts with the Veterans Administration. Texas is not one of them and to date a plan of medical care for veterans has not been submitted by the State Medical Association of Texas to the Veterans Administration.

CONCLUSIONS

The Veterans Administration program for medical care of eligible veterans is still expanding and the foregoing procedures may soon be altered. It would seem advantageous for the State Medical Association of Texas to participate in the program for private treatment of veterans with service-connected disabilities. The Veterans Administration is to be commended for the revolutionary stand which permits veterans to choose their own private physician and, if necessary, to enter a civilian hospital. With the shortage of physicians in the Veterans Administration, it is hoped that the free choice of a doctor will be extended to all honorably discharged servicemen, because many veterans with service-connected disabilities refuse to accept treatment in a government hospital. It is a regrettable, but not illogical attitude, since the vital physician-patient relationship that is so essential to successful treatment has not existed in state-supported medicine. The entire neuropsychiatric training program of the Veterans Administration is designed to train young physicians to understand a patient's needs and it should soon eliminate this particular complaint.

In addition to provisions for medical care of returning servicemen, something must be done to preserve the health of veterans and to promote recovery in those who have recoverable illnesses. It will be recalled that the psychoneurosis is a recoverable illness and with proper management, this large group of veterans can be restored to health. This would lighten the future load considerably. The number of veterans with service-connected psychoneurosis who are entitled to a pension is unknown. Persons with a psychoneurotic illness seldom recover while drawing a monetary reward, even though the compensation represents but a small fraction of their former earnings. Congress should be encouraged to enact new laws providing for some type of final monetary settlement in the case of veterans who have a psychoneurosis. The furor in service organization circles would be great, but the public can be educated to understand that this is both a practicable and desirable idea. Once a final settlement has been made, recovery with treatment is possible, as it removes a stimulus for the person to remain ill.

Until late in the war, thousands of maladjusted personalities who developed situational anxiety in response to unpleasant military assignments were given a medical discharge with a diagnosis of psychoneurosis. These men simply were ineffectuals in the military service, for they had previously adjusted to civilian life and can again adapt themselves if the incentive to do so is produced. Many of them experience feelings of guilt about receiving a medical discharge and this is abetted by a sense of failure in military life. Both conscious and unconscious motives operate to continue the illness in order to protect their self esteem. A careful review of their medical records by a competent medical board having the authority to remove unwarranted diagnoses and grant a nonmedical form of discharge would help to remove the need to continue the illness. The accomplishment of such proposals can attain fulfillment when supported by the medical profession.

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John Sealy Hospital.

ABSTRACT OF DISCUSSION

Dr. A. Hauser, Houston, one of the most progressive steps that the medical department of the Veterans Administration has made was the decision to locate hospitals near medical centers and medical schools. Now, as Dr. Ford has outlined in his paper, the Veterans Administration has blueprinted an excellent plan for the treatment of veterans during the next twenty years and for training the physicians who will administer the treatment. At present, the acutely ill veteran, including the psychiatric patient, can obtain admission into a Veterans hospital quickly—but it is a different story for the veteran who does not desire to go to the Veterans Administration hospital, and whose illness might not have been proven to be service-connected.

An elderly patient with a severe agitated depression and suicidal trends recently came under my care. He was a veteran of the Spanish American War, and his family desired his admission to the Veterans hospital at Waco. After application, he was admitted to the hospital within forty-eight hours.

Another patient, a young male veteran of World War II, who had served with the Marine Corp in Japan, had been discharged with a beginning depression. When the patient came to my office, he had developed a full blown psychosis and needed immediate treatment Neither the patient nor his brother wished care in a Veterans Administration hospital. He was given ambulatory shock treatment with excellent results and was saved from self destruction. When he applied to the Veterans Administration for reimbursement of medical expenses incurred, he was informed that because his condition was considered nonservice-connected, nothing could be done. This action was an obvious injustice and an extremely inefficient method of handling such a case. This veteran will probably have to traverse a rocky path of red tape before his case is properly adjudicated.

Dr. Ford's suggestion of lump sum liquidation for chronic psychoneurotic cases deserves careful consideration. Will such a method boomerang back in an unfavorable direction?

In closing my discussion, I wish to express my appreciation to Dr. Ford for bringing this very timely discussion before us. His paper has been thought provoking and stimulating. We shall need more education on these matters for many years to come.

PRIMARY ATYPICAL PNEUMONIA WITH A REPORT OF SIXTY CASES

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Primary atypical pneumonia has increased in prevalence during the past decade. It probably extended as far back as 1872,[2] however, when a similar clinical syndrome was described; the apparent current increase is primarily the result of the widespread use of roentgen examination of the lungs. In the United States Army[15] primary atypical pneumonia has constituted 20 to 25 per cent of all respiratory infections and 75 to 80 per cent of all pulmonary lesions. The purpose of this paper is to present a statistical study on 60 cases seen in civilian practice, showing its high incidence in the civilian population, with a brief review of the pertinent literature.

Etiology.—The etiology of primary atypical pneumonia has not been definitely established but great progress has occurred in the past few years. Many authors think it is an old disease assuming epidemic character because of either a change in the virulence of the causative agent or an increase in individual susceptibility. Many investigators[4,19] have isolated viruses which closely resemble the so-called primary atypical pneumonia virus. Comparable viruses are known to be the causative factors of lymphogranuloma venereum, psittacosis, lymphocytic choriomeningitis, and influenza A and B.[11] A nonhemolytic streptococcus has been isolated by Thomas and others[16] from the lungs and sputa of patients with primary atypical pneumonia. Specific antibodies directed against this species of streptococcus have been demonstrated in the convalescent serum of patients with the disease.

More recently the Commission on Acute Respiratory Diseases of the United States Army has been able to transmit the disease to volunteers from the throat washings and sputum of patients. Since untreated and filtered materials were equally successful in the production of the disease, a filtrable agent would appear to be responsible. The Commission thinks the pneumonia is transmitted by contact or droplets. Other infections, characterized by atypical pneumonia, which clinically closely resemble virus pneumonia are American Q fever, coccidiosis, ornithosis, toxoplasmosis, and certain rickettsial diseases with pneumonic manifestations.

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Pathology.—The most extensive pathologic studies to date are those reported by Golden[6] on a series of 90 autopsied cases in the United States Army. The basic pulmonic lesion is an acute interstitial pneumonitis, which in cases uncomplicated by secondary bacterial invaders showed involvement of variable numbers of bronchioles. The bronchiolar walls are heavily infiltrated with round cells and lymphocytes, and they are markedly edematous. Lymphocytic and mononuclear cellular infiltration of the alveolar walls are observed in contrast to the changes seen in bacterial pneumonia. There is a great tendency for secondary bacterial infection as in other virus pneumonias.

Symptoms.—Clinically, primary atypical pneumonia appears in two forms. It may occur concomitantly in epidemics of a mild or moderately severe disease of the upper respiratory tract, which tend to occur in Army camps, hospitals, and institutions especially in the young adult age group (table 1). However, some cases are isolated, sporadic, disseminated, and nonseasonal, of mild to severe degree, and may occur in any age group. The clinical course consists of an insidious febrile onset, with a progressively regular rise and fall of temperature, without diurnal regularity, reaching at times 103 to 105 F. after the first day or two (table 2). The fever is accompanied by progressive malaise, weakness, generalized aches, profuse diaphoresis, and often severe headache (table 3). The headaches are frequently frontal in location,[7] boring in nature, and of a marked severity. Some degree of chest pain is present in about one-third of the cases, but it is not as common as in lobar pneumonia because the disease tends to limit

TABLE 1.—*Age and Sex Distribution, Primary Atypical Pneumonia.*

Age: Range was from 15 to 65 years.

Years	No. Cases	%
15-20	12	20
21-30	36	60
31-40	8	13.3
41-50	1	1.7
51-60	2	3.4
61-70	1	1.7

Sex: 34 of the 60 were males = 56%.

TABLE 2.—*Temperature, Primary Atypical Pneumonia.*

Admission Temperature: Range, 98.6 F. to 105.2 F.; Average, 102.2 F.

Highest Temperature Reading at Any Time:

	No. Cases	%
Less than 101 F.	17	28.3
101-103 F.	21	35.0
101-105.2 F.	22	36.7

Types of Fever:	No. Cases	%
Continuous (oscillations less than 2 degrees F.)	11	18.0
Remittent (oscillations greater than 2 degrees F.)	47	78.3
Transient secondary rise	8	13.3

itself more to the hilar region of the lung. Shaking chills are rare, but a chilly sensation is common and may be associated with diaphoresis. On the third and fourth days, a nonproductive cough develops. Later the patient may raise whitish phlegm, and in a small per cent it may be blood tinged. Occasionally the disease is accompanied by meningeal symptoms, constipation, abdominal pain, or abdominal distention. The slowly developing crescendo type course lasts ten to twelve days (table 4). Decrudescence by lysis usually occurs, but in a few cases there is a migration of signs and recrudescence of severity.

TABLE 3.—*Symptoms, Primary Atypical Pneumonia.*

Symptoms		No. Cases	Frequency
Headache	Frontal	33	55.0
	Generalized	9	15.0
	Occipital	4	6.6
	None	14	23.4
Diaphoresis		37	61.0
Vomiting		9	15.0
Constipation		12	20.0
Cough		60	100.0
Chest Pain		22	36.0
Backache		15	25
Malaise		50	83.3
Restlessness		15	25
Stiff Neck		10	16.6

TABLE 4.—*Course, Primary Atypical Pneumonia.*

Duration of fever while in the hospital:	
Range, 0-16 days.	
Average duration, 5.5 days.	
More than 10 days, 10 cases, 16.6%.	
Defervescence by lysis, 49 cases, 81.6%	
Length of Hospitalization:	
Range, 2-36 days.	
Average duration, 15 days.	
More than 15 days, 22 cases, 35%.	

Physical Signs.—The objective manifestations are conspicuous by their absence (table 5). In many cases for the first four or five days no chest abnormalities whatsoever are present. In about 60 per cent of the cases, after the first three days of the disease, fine or medium moist rales make their appearance in the involved areas. It has been my experience that these rales often shift from one location to another in one lung, and also to the opposite side, without any definite roentgenologic evidence of new involvement. Occasionally sibilant or sonorous rales may be heard. The respiratory rate usually runs between 20 and 30 per minute. In only 10 per cent of the cases is impaired resonance found, and in a similar number bronchovesicular breath sounds are heard. A few investigators[7] report splenomegaly in some cases, and a relative bradycardia is present. An injected pharynx is found in about one-fourth of the cases.

TABLE 5.—*Physical Observations, Primary Atypical Pneumonia.*

Crepitant Rales:	36 of 60 cases on admission	= 60%
	57 of 60 cases developed rales	= 95%
Respiratory Rate:	Range, 18-34 respirations/minute.	
	50 had rate less than 25/minute	= 83.4%
	10 had rate more than 25/minute	= 16.6%
Suppressed Breath Sounds:	9 of 60 cases	= 15 %
Impaired Percussion Note:	7 of 60 cases	= 11.6%
Palpable Spleen:	6 of 60 cases	= 10.0%
Injected Pharynx:	15 of 60 cases	= 25 %
Heart Rate:	23 did not exceed 90/minute	= 38.3%
	29 ranged 90 - 110/minute	= 48.0%
	6 ranged 110 - 130/minute	= 10.0%
	1 was above 130/minute	= 1.6%

Roentgen Evidence.—Radiographic proof (table 6) of the pulmonic lesion is the one objective criterion required by most authorities to establish the diagnosis of primary atypical pneumonia. Fredd[5] found that it occurred in 0.27 per cent of 23,465 clinically well persons. It usually appears after the first two to three days of illness. Only 32 per cent of cases are diagnosed from history and physical examination.[17] Scadding[14] divided the cases on the basis of roentgenographic evidence into two main groups: The first group, which constitutes the majority, consists of a benign circumscribed pneumonia, which is fairly well localized but not sharply defined, of uniform density, and located usually in the lower lobes. The second group, which constitutes less than 10 per cent of any reported series, consists of the disseminated focal pneumonia which produces a picture of diffuse, rather coarse mottlings with foci varying from 2 to 5 mm. in diameter. It is usually in a segmented lobular distribution rather than lobar.

TABLE 6.—*Roentgen Manifestations, Primary Atypical Pneumonia.*

Location	No. Cases	%
Left Base	21	35
Right Base	15	25
Both Bases	2	3.3
Right Cardiophrenic Region	2	3.3
Right Upper Lobe	12	20
Left Upper Lobe	3	5
Right Upper and Right Middle Lobes	1	1.6

The first roentgenologic evidence is an increase in bronchial markings, most pronounced at the hilar areas, followed shortly by irregular patches of increased density further peripherally. The density is not as pronounced as that of lobar pneumonia,[7] but a soft mottled, hazy, or glazed appearance is noted. In addition resolution is frequently prolonged, and increased bronchial markings and some parenchymal mottling may remain long after the patient is clinically well. The resolution starts first at the periphery and progresses toward the hilum. Recently Adams and others[1] emphasized the importance of lateral chest films for accurate localization of the lesions.

Laboratory Observations.—Cold hemagglutinins (table 7) may be absent but when present they usually begin to rise in titer from the sixth to the tenth day[7] and reach

their peak by the tenth to the fourteenth day. The height[15] of the cold agglutinin's titer bears no definite relationship to the severity of the disease. A few investigators[17] have found agglutinins for an indefinite streptococcus.

Sedimentation rates give a notably poor correlation with the roentgen findings. Early in the course of the disease, the leukocyte count is relatively low, that is 10,000 or less in about 84 per cent of the cases, but in the later stages a mild leukocytosis, with a count of up to 12,000 to 14,000, may develop. A transient albuminuria may occur if

TABLE 7.—*Laboratory Findings, Primary Atypical Pneumonia.*

Leukocyte Count:	Range, 3,200 to 16,500; average, 7,800. Less than 10,000, 84%.	
Cold Hemagglutinins:	6 tested—4 positive between eighth and fourteenth days; 2 negative.	
Sputum:	40 cases had sputum examination for organisms.	
	Tubercle bacillus — all negative.	
	Beta-hemolytic streptococci — 9 positive,	22.5%
	Higher types of pneumococci — 3 positive,	7.5%
	Blood tinged — 5,	8.3%

sufficient hyperpyrexia is present. A heterophil antibody reaction using horse cells has recently been reported by Adams and others.[1] A titer of 1:448 (horse cells) was considered to be a significant positive. Thirty-six per cent of their cases gave titer of this degree at some stage of the disease.

Complications.—The complications of the disease (table 8) are relatively few in most series; however, in a report by Higley and others,[8] 42 per cent of 202 cases had some type of complication. Pleurisy occurred in 19 per cent, pleural effusion in 2 per cent, and empyema, atelectasis, lung abscess, nonpurulent arthritis and pericarditis each occurred in less than 1 per cent. Van Ravens-

TABLE 8.—*Complications, Primary Atypical Pneumonia.*

	No. Cases	%
Pleural Effusion	2	3.3
Interlobar Effusion	1	1.6
Thickened Pleura	1	1.6
Urticaria	1	1.6
Otitis Media	2	3.3
Maxillary Sinusitis	1	1.6
Total	8	13.2

waay and others[18] thought that complications were most likely to occur in those patients allowed to be ambulatory too soon. In 500 cases reported by Karpel and others less than 3 per cent had complications. Bronchiectasis[9] is most likely to occur when the atypical pneumonia has a protracted course and particularly when it is associated with roentgenologic evidence of unrelieved atelectasis. Two cases of meningomyelitis have been reported,[13] and fibrinous pericarditis, migrating periarthritis (jaundice, and erythematous skin eruptions were observed by Kneeland and Smetana.[10] The average hospital stay in many cases was prolonged by weakness, a persistent cough, rales, and relatively slow resolution of the pneumonic process. In a few cases maxillary sinusitis, otitis media, and peritonsillar abscesses occurred, but these were thought to be secondary to the upper respiratory tract infection.

Treatment.—As in many diseases, rest in bed appears to be the best treatment. Though prevailing opinion considers the sulfonamides of no value, there are some who urge their use to forestall secondary bacterial invasion, and in any event there is no contraindication to chemotherapy. If no response is obtained after two to three days of full doses and at adequate blood levels, the drug may be discontinued.

If the pleural pain is severe, procaine hydrochloride injections[7] of the intercostal nerves at the proper levels may be beneficial. Scultetus binders,[3] hot water bottles, or an electric pad may give relief from the pain.

The use of oxygen is indicated if either cyanosis or dyspnea is present. Steam inhalation, throat irrigations, and expectorants may be beneficial. As in other upper respiratory tract infections, fluids should be forced. Lumbar punctures may be tried in an attempt to relieve the more severe headaches and have been found by some investigators,[3] including myself, to be quite helpful. Codeine continues to be the best medication to suppress the cough.

Convalescent serum[19] given in small repeated doses has been of some value in a few reported cases. Salicylates[3] probably should be avoided unless the patient is suffering from a high fever and is not sweating. Thiamine hydrochloride and nicotinic acid[3] have been used to prevent delirium.

Roentgen therapy has had a limited trial in the treatment of primary atypical pneumonia. Oppenheimer[12] first introduced roentgen therapy with good results to control the cough in the late stages of the disease in those patients who developed a refractive cough. Later he obtained the best results when roentgen therapy was employed in the early stages. Other investigators have used slightly larger doses of roentgen therapy and repeated it in twenty-four hours if the clinical response was unsatisfactory. In 23 of their treated cases, 22 responded. The number of sick days and the hospital stay were reduced to half. Nine patients with unresolved pneumonia after thirty days were given roentgen therapy, and their lungs all cleared in four days or less.

Differential Diagnosis.—Numerous diseases enter into the differential diagnosis of primary atypical pneumonia, but primarily those of an acute nature which involve the respiratory system need be differentiated. Lobar pneumonia is characterized by an abrupt onset, a continuous fever, marked leukocytosis, and extensive pulmonary manifestations in contrast to primary atypical pneumonia with its slow onset, remittent type of fever, normal leukocyte count, and comparatively few lung manifestations. Finally the typical roentgenologic appearance of the two diseases completes the differential picture.

Influenza may also be confused with atypical pneumonia. With influenza there is usually an abrupt onset, prostration, repeated chills, a loose cough, often bloody sputum, a remittent type of fever, and frequently more severe dyspnea and cyanosis. Influenza virus when introduced into ferrets causes specific antibody reaction and therapy allows accurate diagnosis.

In differential diagnosis must also be included bronchopneumonia, which most characteristically occurs in very young and elderly persons, in contrast to the adolescents and young adults who commonly develop atypical pneumonia. Bronchopneumonia more often follows other diseases such as diphtheria, measles, and whooping cough, or appears in the terminal stage of many severe infections. Finally the appearance of the roentgenogram is very different in the two conditions.

Tuberculosis, especially of the acute exudative variety frequently has to be considered when the apices are involved with atypical pneumonia. The negativity of the sputum and the rapidity of resolution of the lesion belies the seriousness of the first impression.[20] Serial roentgenograms of the chest, at short intervals, are the best guide to the relative benignancy of the condition.

Pulmonary infarction may be differentiated from atypical pneumonia by the sudden severe chest pain, abrupt rise in temperature, grossly bloody sputum, and the presence of a contributing etiologic factor, such as heart disease or pelvic thrombophlebitis. Again the roentgenogram is helpful in differentiating the two diseases.

A severe common cold at times very closely resembles primary atypical pneumonia, and a negative chest roentgenogram may be the only method of ruling out a pneumonitis.

In the period before development of characteristic pulmonary signs,[1] especially in Army life, the diagnosis was often in doubt between malaria, infectious mononucleosis, fevers of the enteric group, meningoencephalitis, and infective hepatitis.

In most reported series there have been no deaths from the disease. Karpel and others have found a mortality of 0.2 per cent in their series of 500 cases.

DISCUSSION

The increased use of the roentgenogram has demonstrated a picture that is characteristic and differing in its development, course, and resolution from that of bacterial pneumonia and in some cases it has revealed the presence of the disease in the absence of other evidence. The absence of dyspnea, tachycardia, cyanosis, and minimal physical signs are probably caused by the interstitial character of the disease. Proper treatment depends on recognition of its high incidence and also the pathologic symptoms and lack of correlation between the physical and roentgen signs.

Convalescence ordinarly is prolonged but uneventful and recovery the rule. In Army practice[18] the patient was kept in the hospital until the temperature had been normal for two weeks, a consistently low sedimentation rate was obtained, and he could tolerate exercise without reactivation or impaired clearing of the roentgenogram. In civilian practice convalescent periods have been shortened because of different existing circumstances.

SUMMARY

A statistical study of 60 cases is reported with factors relative to signs, symptoms, course, and complications. A brief review of the pertinent literature is also presented.

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ABSTRACT OF DISCUSSION

Dr. Carl F. Shaffer, Houston: Dr. Chapman has been able to condense to a short period of time an extensive subject. There is no other pulmonary disease that has received more notice in the literature in the past five years than primary atypical pneumonia. This may eventually become the "typical" pneumonia, and the bacterial types, because of their control by chemotherapy and antibiotic therapy, become less common.

The etiology of this disease has been fairly definitely established. The importance of the differential diagnosis from the influenzal type of respiratory infection is a point that I want to mention. This may be of value in regard to treatment of the acute phase of these illnesses. The serious consequences of influenza, especially in the epidemic form, are the development of secondary bacterial infections. In this respect, the use of penicillin may be important for the reduction of mortality in epidemic influenza. A typical pneumonia does not have as comparatively frequently, the secondary bacterial infection that may result in immediate mortality. But, since it is possible that atypical pneumonia may be pathogenic for certain chronic pulmonary diseases, especially bronchiectasis, and because penicillin is innocuous, aside from hypersensitivity reactions that occur in a small number of persons, it may be advisable to give this antibiotic to reduce the frequency of chronic pulmonary complications. Penicillin aerolization has been reported to be therapeutically effective in established cases of bronchiectasis. The routine use of this particular method may be an effective means of preventing this and similar chronic pulmonary complications.

SOCIAL FACTORS IN TUBERCULOSIS

When the wage earner is stricken with tuberculosis, a tremendous adjustment is required in the living habits of the other members of the family. The steady income usually ceases abruptly, and the family provider is reluctant to enter a sanatorium, leaving his family unprovided for. A mother contracting tuberculosis is also loath to enter a sanatorium until reasonable provision has been made for the care of her children.

Many of these social and economic factors, which inhibit the control of tuberculosis, may be overcome if the welfare agency, in coöperation with the health authorities, takes a liberal and generous attitude toward the other members of the family who are potential cases of tuberculosis. Money spent in this manner should not be looked upon as charity, but as an investment or insurance by the state or municipality against future and large expenditures, which will undoubtedly follow if a niggardly policy is followed. Penny-wise policies will only add to the burden of the future taxpayer. It must never be overlooked that every case of tuberculosis prevented is not only money saved to the treasury but a life to the nation.—Canad. Pub. Health J., Jan., 1946.

JAUNDICE IN THE NEWBORN INFANT

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There has been so much written in recent medical literature about erythroblastosis fetalis that I think it may be well to review some of our experiences with jaundice in newborn infants, particularly with varieties due to causes other than erythroblastosis. There is ample evidence that there is little excretion of bile prior to birth so that the problem is complicated by occurring at a time when this function of the liver is being established. There are more changes in body physiology in this period of life than at any other time from conception to senility.

PHYSIOLOGIC JAUNDICE

Although only about one-half of newborn infants become detectably jaundiced, the serum will with rare exceptions show some elevation of the icterus index, even in the cord blood. The most apparent explanation of this jaundice is that it is a hemolytic type—a result of the reduction of the polycythemia of the fetus with the production of bilirubin more rapidly than the liver is able to excrete it. If this is the only factor, there should be some demonstrable relation between the degree of blood destruction and the degree of elevation of the icterus index. That this is not true has been previously shown (fig. 1).

Ross and associates[9] found the average total excretion of bilirubin and urobilin in the stools during the neonatal period to be lower in infants visibly jaundiced than in those not visibly so. Moreover, the total excretion of urobilin in the urine was lower in infants visibly jaundiced. Neither of these findings is in keeping with a purely hemolytic jaundice. The obvious assumption is that there must also be some impairment of hepatic function present during this period of life. However, various liver function tests have not shown variations of results in newborn infants which can be correlated with variations of the icterus index.[10]

Although it is a time-honored custom to attribute many symptoms in newborn infants to physiologic jaundice, it is becoming more and more apparent that this is a normal process and without symptoms other than icterus. Almost never present at birth, the jaundice makes its appearance in the first few days of life and rarely lasts longer than twelve or fourteen days. Although it is

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usually slight in degree, I have observed infants whose icterus index reached 75 to 100.

CONGENITAL ATRESIA OF THE BILE DUCTS

The cause of congenital atresia of the extrahepatic tracts is obscure, as is the cause of most congenital anomalies. The atresia may involve only portions of the extrahepatic ducts or their entire course. Apparently in some cases the extrahepatic ducts are congenitally absent.

The most outstanding symptom is jaundice. It is absent at birth and its early course is similar to that of physiologic icterus except that it persists and steadily increases to a marked greenish bronze.

The surprising thing about the jaundice, in these cases is that it is always much more marked than either the quantitative Van den Bergh test or the icterus index indicate. This is probably because much of the color is due to green biliverdin, an oxidation product of bilirubin, which does not react with the diazo reagent used in the quantitative determination. Not only is the jaundice more severe than the icterus index indicates, but the icterus index frequently shows surprising daily fluctuations. This is because the color of the serum is actually not even the same color as the dichromate standard. The standard is yellow; the unknown serum is a greenish yellow. Since an accurate comparison is impossible, an estimate is usually made, and this estimate may vary from day to day. Moreover, since the quantitative Van den Bergh test and icterus index actually measure two different properties of the serum, results obtained with the two tests show no constant relation to each other.

The facts are very well illustrated in the 2 cases of congenital obstructive jaundice of figures 2 and 3. In neither case did the icterus index exceed 200, yet from the intensity of the jaundice one would have expected it to have been much higher. The results of the quantitative Van den Bergh tests are not tabulated but they varied between 12 and 18 mg. per 100 cc. of serum, surprisingly low figures for the intensity of the jaundice.

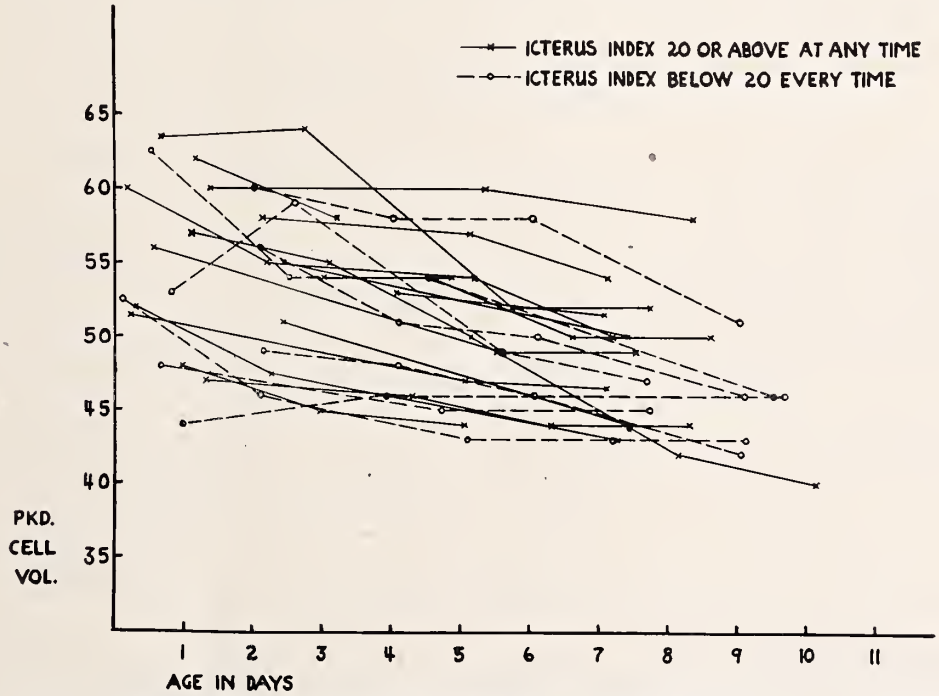

FIG. 1. Seventy-nine packed cell volume determinations on 24 newborn infants from 2 to 243 hours of age. Reproduced from Salmon and Richman[10] with permission of the editors of the *Journal of Pediatrics*. There is no correlation between the degree of blood destruction and the icterus index.

The stools of the first few days of life resemble normal meconium. After this time the stools are classically characteristic of those seen in complete obstruction—pale gray or white in color and putty-like in consistency.

The nutritional status is usually poor but it is always surprisingly good when consideration is given to the fact that there has never been bile in the intestinal tract. As the weeks and months go by it becomes apparent that development is delayed.

The liver is very firm, smooth, and en-

larged, frequently reaching the level of the umbilicus. Probably because of the marked biliary cirrhosis which develops and the ensuing portal hypertension, the spleen enlarges and after several months ascites may appear.

Some of the constitutional sequelae of the digestive defect may not appear for months and even then may not be severe. Bone changes appear which are probably the result of a combination of rickets and the loss of large amounts of ingested calcium as soaps in the stools. I have never seen clinical symptoms of vitamin A deficiency. A remarkable aspect of these cases is that the infants do not develop hypoprothrombinemia until after several months have gone by, and even then the plasma prothrombin concentration usually does not drop below 20 per cent so that the coagulation time of the blood remains normal. When hypoprothrombinemia does occur it seems to be as much a result of inability of the liver to use vitamin K, probably because of the marked cirrhosis, as it is the failure of absorption. The prothrombin response after the administration of vitamin K in both of these cases (fig. 2 and 3) indicates impaired liver function. The plasma prothrombin concentration remained low in case B. K. even though oral bile salts were administered. This presumably might have improved the absorption of vitamin K from the intestinal tract. On the other hand, in case J. A. D. after twelve days administration of oral bile salts, the plasma prothrombin concentration rose to 70 per cent. After the appearance of biliary cirrhosis the metabolism of carbohydrates may be impaired as may be that of proteins.

The qualitative Van den Bergh test shows an immediate direct reaction. The urine contains no urobilinogen; it does contain large amounts of bile pigments.

It is important to realize that every one of these infants should have an abdominal exploration. Of 45 cases mentioned by Ladd and Gross[5] 9 were amenable to surgery. Without surgical correction the course is slowly but progressively down hill. Most die in the first year of life; a few survive several years.

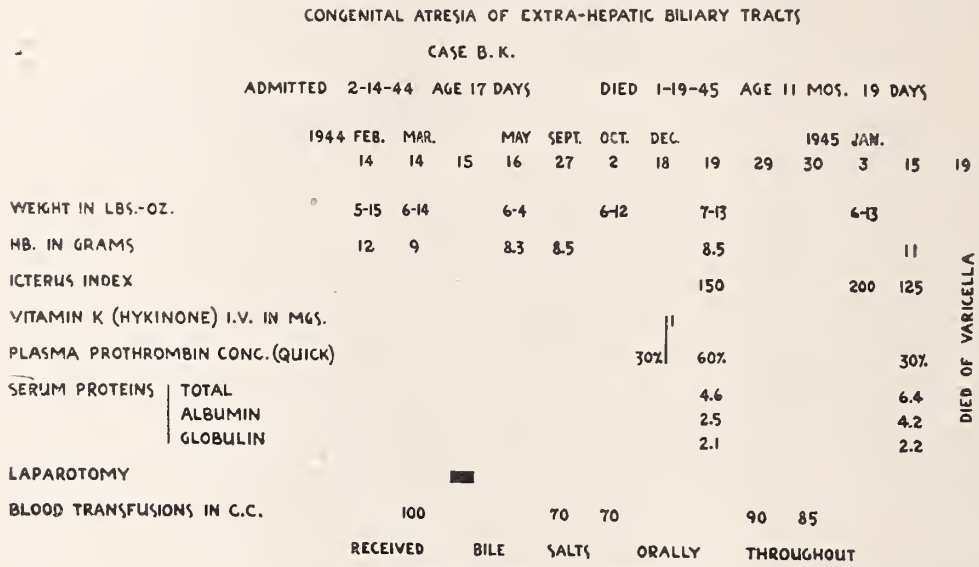

FIG. 2. Congenital obstructive jaundice.

CONGENITAL OBSTRUCTIVE JAUNDICE FROM INSPISSATED BILE OR MUCUS IN THE BILIARY PASSAGES

A clinical picture identical with that of congenital atresia of the bile ducts may be produced by obstruction due to inspissated material, presumably bile or mucus. The history in a few of these cases may indicate that the jaundice has been intermittent or at least has varied in severity and that the stools have at times contained bile. I have recently seen such a case in a 3 month old male infant. At operation no anatomical obstruction was found. The cystic, hepatic, and common ducts were probed. Following operation bile appeared in the stools and the jaundice subsided.

Ladd and Gross[5] reported 9 such cases. They recommended laparotomy and irrigation of the extrahepatic ducts with saline solution introduced by way of the gallbladder.

SEPTICEMIA OF THE NEWBORN INFANT

The streptococcus, staphylococcus, or colon bacillus is the most frequent pathogen. The portal of entry may or may not be apparent. Not uncommonly it may be an umbilical, skin, urinary, or upper respiratory infection. In some cases the origin has apparently been prenatal, the same bacteria being recovered from the blood of the mother and of the infant.

Symptoms may be present at birth or appear at any time in the newborn period. The clinical picture is quite varied and erratic but usually includes some combination of these symptoms: fever, failure to eat and gain, vomiting, diarrhea, jaundice, bleeding, enlarged spleen and liver, leukocytosis, immature leukocytes, anemia, nucleated erythrocytes. Metastatic infection in the skin or in various parts of the body such as the meninges, bones, and peritoneum is not uncommon.

The pathogenesis of the jaundice in these cases is not clear. In Dunham's series of 39 cases[3] 3 with marked jaundice had postmortem examinations. In 1 case the liver showed chronic hepatitis, in another diffuse fibrosis, and in the third central necrosis. Jaundice occurred in 14 of the 39 cases and progressive anemia in only 2; apparently the jaundice is not hemolytic in type.

Therapeutic measures include penicillin, sulfonamides, transfusions, and supportive therapy.

I have seen but 4 cases of septicemia in newborn infants that were studied sufficiently well to mention here. Only 1 became jaundiced. The blood culture showed a nonhemolytic streptococcus. The infant did not survive and permission for an autopsy could not be obtained.

BUHL'S DISEASE AND WINCKEL'S DISEASE

Mention of these varieties of jaundice in newborn infants is much more common in older than in recent medical literature. It is probable that they were actually sepsis. In recent years with more common use of blood cultures it is likely that these cases are being diagnosed as septicemia.

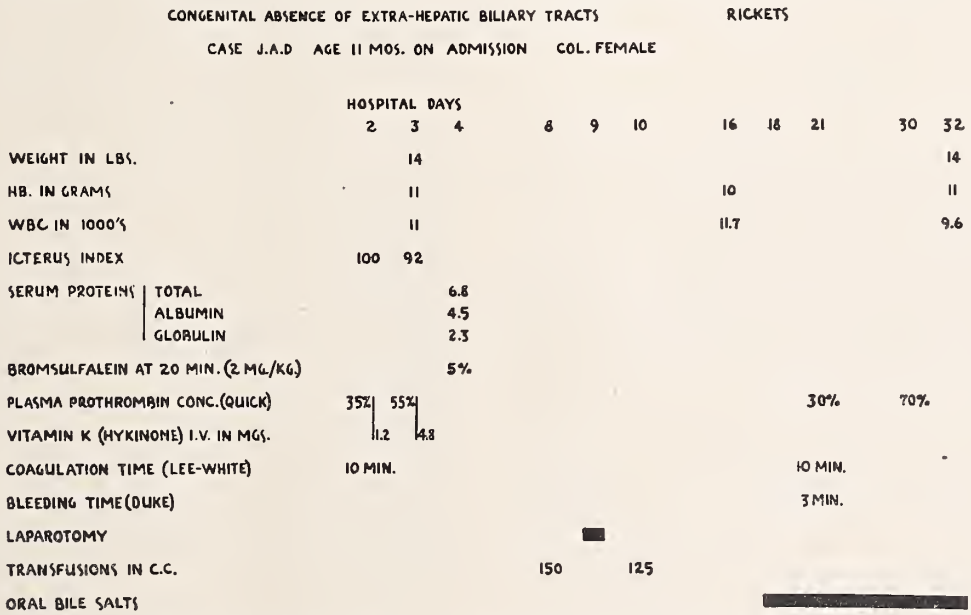

FIG. 3. Congenital obstructive jaundice. In the bromsulfalein dye test using 2 mg. per kilogram of body weight, none remains in the blood of a normal infant at twenty minutes.[10]

CONGENITAL SYPHILIS

Although pathologically the liver is one of the most frequent organs to be involved in congenital syphilis, jaundice is a rather unusual symptom. The pathologic lesion may be an interstitial or a gummatous hepatitis; the former is much more common.

The age of onset of the jaundice may be at any time in the first few weeks and may be as long as six weeks. There may be fever, leukocytosis, and other constitutional symptoms. The liver and spleen are usually enlarged. There may be an increase in the number of nucleated erythrocytes in the peripheral blood. Although this combination of symptoms may lead to confusion, the presence of associated manifestations of syphilis usually clarifies the diagnosis. The serologic condition of the mother is almost invariably positive. The serologic condition

of the infant may be negative; if positive, it is of definite help only if repeated observations show a rising titer. Roentgenograms of the long bones will frequently show changes typical of congenital syphilis. The qualitative Van den Bergh test may show either a biphasic or immediate direct re-

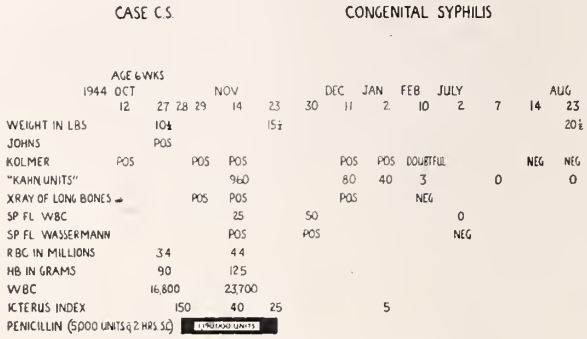

FIG. 4. Jaundice caused by congenital syphilis.

action, depending on the stage of hepatitis. The urine may contain both bilirubin and an excessive amount of urobilinogen.

The results of the significant laboratory examinations in a typical case of jaundice in congenital syphilis together with the response of treatment are tabulated in figure 4. This infant was acutely ill and presented other manifestations of congenital syphilis.

INFECTIOUS HEPATITIS

With the rapid increase in knowledge of acute infectious hepatitis of the past few years it is not inconceivable that such cases

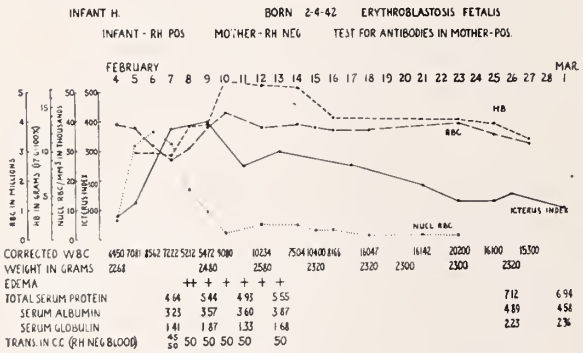

FIG. 5. Erythroblastosis fetalis due to Rh isoimmunization. The term "corrected WBC" indicates that the number of cells counted using acetic acid has been corrected for the number of nucleated erythrocytes.

may soon be diagnosed in the newborn period. I have recently seen a case of markedly severe hepatitis in a 2 month old infant. There was such marked liver damage that the plasma prothrombin concentration (Quick) was but 5 per cent. Although the jaundice was of but a few days duration, gastro-intestinal symptoms began in the first month of life. The case was very thoroughly investigated. The only lead found as to its etiology was that the intern who delivered the infant had acute catarrhal jaundice at the time! Moreover, one of the nurses who cared for the infant developed infectious hepatitis more than a month later.

ERYTHROBLASTOSIS FETALIS

There has been so much written about this disease in the past few years that the advisability of repeating a discussion of it here is doubtful. It might be well, however, to present 2 typical cases and point out some features they illustrate that I do not think are commonly appreciated. Case H. (fig. 5) represents the type seen in about 90 per cent of all cases in that its etiology is obviously immunization of an Rh negative mother by an Rh positive fetus. The etiology of case J. (fig. 6) is not so clear. Both mother and

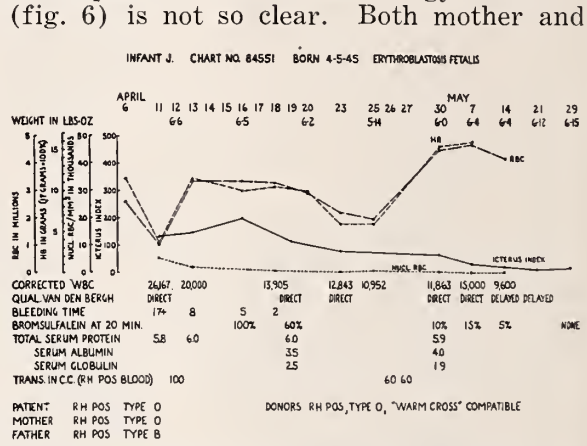

FIG. 6. Erythroblastosis fetalis of more obscure etiology. The blood count of April 6 was performed in another hospital. The blood smear was reported only as "multitude of nucleated RBC."

infant were Rh positive. However, Davidsohn[1] has pointed out that erythroblastosis fetalis may be due to Rh incompatability even though both mother and infant are Rh positive, because they may be of different Rh types. There are eight standard Rh blood types. A second possibility is that of maternal immunization by the Hr factor.[7] Blood from the mother and the infant in this case was not tested for either the various Rh types or the Hr factor. A third possibility is that of maternal immunization by the A or B agglutinogens of the fetus.[8] This could not have been true in this instance since the infant's blood was type O and could have contained neither A nor B agglutinogens. It is well known that the concentration of these agglutinogens may be low in the first few months of life. However, this infant was still type O when rechecked at the age of 11 months.

It will be noted that although case J. became more anemic, case H. developed a higher icterus index. Leonard[6] in a review

of 55 cases has recently offered conclusive evidence that there is no correlation between the degree of anemia and the degree of elevation of the icterus index. This suggests that there is some impairment of liver function. It is interesting that improvement in the bromsulfalein liver function test in case J. was closely correlated with the decline of the icterus index. The administration of vitamin K frequently does not improve the hypoprothrombinemia sometimes found in these cases[6]; this is further evidence of impaired liver function. In so far as I know there is no conclusive proof as to the exact etiology of the impaired liver function. Several suggestions that have been made are that it may be due to compression of liver cells of erythropoietic tissue, to fatty infiltration and fatty degeneration of the liver, or to liver damage due to the antigen-antibody reaction itself.

Leonard has also pointed out the lack of correlation between the degree of anemia and the degree of increase in the number of nucleated erythrocytes in the blood. The tendency for the anemia to recur is very well known. When this happens there is no simultaneous increase in the number of nucleated erythrocytes in the blood nor simultaneous elevation of the icterus index. This is well illustrated in the course of case J.

The jaundice in these cases assumes an orange-yellow hue. This may be the result not only of bilirubin but of a propigment of bilirubin, xanthorubin. As time goes by the jaundice may assume a greenish tint due to the oxidation in the tissues of these pigments to biliverdin.

CONGENITAL HEMOLYTIC JAUNDICE (FAMILIAL SPHEROCYTOSIS)

A crisis of congenital hemolytic jaundice is usually considered extremely rare in the newborn period. Fallon,[4] however, has recently described several cases under age 2 months.

KERNICTERUS

A minor percentage of newborn infants who suffer jaundice show mental and neurological changes. At autopsy the brain shows degeneration plus deposits of bile pigment. These changes are more marked in the nuclear masses, particularly the basal ganglia. This condition has been called kernicterus. It is almost exclusively associated with hemolytic anemia of the newborn.[2]

I have seen only 2 cases of kernicterus; both followed erythroblastosis fetalis. I have seen other cases in which either or both the anemia and jaundice were more marked which did not develop kernicterus. Yannet and Lieberman[11] stated that there is no correlation between the severity of the anemia and jaundice and the occurrence of cerebral damage.

It does not seem that kernicterus should be classified as a separate type of jaundice in the newborn, but rather as a complication, particularly of erythroblastosis fetalis.

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ABSTRACT OF DISCUSSION

Dr. Jack Hild, Houston: The interest manifested by Dr. Salmon in blood dyscrasias in infancy is reflected in the excellence of the resume he has just presented. It should impress upon us the fact that jaundice is not a disease but is a clinical manifestation, the cause of which must be determined in each individual case. The very frequency of physiologic jaundice mentioned by Dr. Salmon may be a stumbling block and cause serious delay in making a correct diagnosis. Every jaundiced baby should be closely observed and should be given the benefit of necessary laboratory determinations. The appearance of the jaundice or, of even more importance, the change of appearance from day to day or over a period of hours may in itself be practically diagnostic. Valuable information can also be obtained by observing the stools. Other observations of importance are pulse and temperature, occurrence of vomiting, weight loss or weight gain, abdominal distention, and enlargement of the liver. These clinical observations alone should help to classify the jaundice as obstructive or nonobstructive. Laboratory determinations are of utmost importance, but there should be no feeling of frustration if elaborate facilities for laboratory work are not available. Almost any hospital or clinic can perform the tests that will corroborate or add to the clinical observations and results in a correct diagnosis, which is essential if proper therapy is to be instituted. Kernicterus is an interesting complication. Its unsuspected presence may explain some of the obscure neurologic findings that occur in later infancy.

EARLY AMBULATION BEGAN IN 1899

In the United States early rising following abdominal surgery was first practiced successfully in 1899 by E. Ries of New York. Most of his patients, including those with hernias, were out of bed on the second day. He found that wound separation and eventration were not more common than with long confinement in bed. One of his colleagues, Boldt, reported in 1907 that he had knowledge of more than 1,000 patients who had been treated by early postoperative ambulation with good results.—Rudolph Marx, M. D., West. J. Surg., July, 1946.

THE PREVENTION OF SYPHILIS IN THE NEWBORN

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GALVESTON, TEXAS

The importance of syphilis to the public health is determined by its prevalence in a population. The amount of congenital syphilis necessarily depends upon the amount of acquired syphilis. The prevalence of syphilis in Texas is such as to make the protection of the newborn a major problem in the control of this disease.

Although the prevalence of syphilis in the female is not accurately known, its distribution in the male population between the ages of 21 and 35 years has been accurately measured in the examination of selectees for military service during the war just closed. These figures afford an approximate estimate of the frequency of infection in the female population.

According to the published figures,[13] 53.4 out of every 1,000 white males in Texas between the ages of 21 and 35 years have syphilis. In the Negro population of the state, 343.2 per 1,000 are infected. The prevalence rate for both white and Negro males is higher in only one other state in the union. The best rate for white males in any state is 6.4 per 1,000 of population, and for Negro males, 91.8 per 1,000. The rates in general for the entire United States are 17.4 per 1,000 for white males between the ages of 21 and 35 years, and 253.3 per 1,000 for Negro males. The position of Texas is indeed not enviable. It is impossible to estimate the cost of this disease to the economy; a burden which all must share.

The prevention of syphilis in the newborn is a problem essentially of prenatal care, and depends upon the detection of the disease in the pregnant woman usually by serologic examination of the blood. Accordingly, all pregnant women, whatever their social status, should have serologic tests made as early in pregnancy as possible. The earlier in gestation the disease is discovered and adequately treated, the better are the chances for a normal child. Treatment will prevent syphilis in the newborn in most cases, provided it begins early in pregnancy, continues regularly, and is of the proper kind and amount. Even when given late in pregnancy, treatment is remarkably efficacious as a preventive measure.

From the Department of Dermatology and Syphilology, University of Texas School of Medicine, and the University of Texas Venereal Disease Clinic, State Department of Health, Galveston.

The work described in this paper was done under a contract recommended by the Committee on Medical Research between the Office of Scientific Research and Development and the University of Texas.

Read before the Section on Obstetrics and Gynecology, State Medical Association of Texas, Annual Session, Galveston, May 8, 1946.

It is not enough, however, to make sure that serologic tests of the expectant mother give negative results. It should be remembered that syphilis may be, and frequently is, contracted during pregnancy. Under such circumstances, the identification of the primary lesion, if one be present, can be made by demonstrating the causative organism on the surface of the lesion by dark field examination. Negative serologic tests before the appearance of the primary lesion, or during the early days of its presence, are no guarantee against infection of the fetus. Unrecognized, the disease will progress to its most infectious stage during a few short weeks. Only by frequent and thorough examination of the external genitalia can infections acquired in pregnancy be recognized. During the past three years, I have been impressed by the number of seronegative cases of primary syphilis which have been detected in an alert antenatal clinic.

Since the days of Jonathan Hutchinson,[7] it has been recognized that pregnancy exerts a modifying influence upon the clinical course of syphilis. The infection may be suppressed sufficiently to reduce the disease to a low clinical level. Hence, minor abnormalities of the genital mucosa, if subjected to dark field examination, may be found syphilitic. Such lesions occur not infrequently in the local population. In fact, they occur so often, the obstetrical service is ever aware of the possibiilty.

If resistance to syphilis in a woman is enhanced by pregnancy, so much can not be said of the fetus. Before women were treated regularly for syphilis during their pregnancy, this disease was considered by Williams[14] to be the largest single cause of fetal mortality. It was his impression that a third of all fetal deaths were from this cause.

There is a prevailing misconception that pregnancy affects the serologic reaction for syphilis. It can be stated that pregnancy is not a cause of biologic false-positive Wassermann reactions. A corroborated positive test is an indication of syphilis in the pregnant woman, except under circumstances known to cause false-positive reactions, such as, among others, malaria[9] and the prophylactic inoculation against smallpox.[11] Neither does pregnancy act to reduce the titer of syphilitic reagin in the blood. In early syphilis the titer is quite as high in a pregnant woman as in one who is not pregnant.

It is also essential to know the significance of positive serologic tests on the cord blood. In this case, positive reactions are usually a measure of reagin carried across the placental barrier from the mother's blood. As such, they indicate the disease in the mother and not in the infant. Although not a re-

liable criterion of syphilis in the infant, the test on the cord blood is a valuable procedure for the diagnosis of syphilis in an otherwise untested pregnant woman. It is, therefore, highly desirable that the test be made in all cases at the time of delivery. Being positive, it affords presumptive evidence of syphilis in the infant; but not as good evidence as was once thought.[12] It was formerly assumed that fully 80 per cent of infants whose cord blood is positive have congenital syphilis. Perhaps a more accurate estimate is in the neighborhood of 14 per cent. When the test is positive, however, the infant should be examined serologically at intervals of not more than one month until it is at least 3 months old, and preferably 6 months old.

At the time of birth, a positive reaction on the blood of the infant is no more reliable as an indication of congenital syphilis than is a positive reaction on the cord blood. At this early period of life, a positive reaction is usually due to reagin from the blood of the mother, and as such it is transient in character.

As long ago as 1915, Fildes[5] initially observed that the presence of complement-fixing antibodies in the cord blood of the infant is evidence of syphilis in the mother rather than in the child. Subsequently, Cruickshank[2] learned that blood of the infant which gives a positive complement fixation reaction at birth may become negative with the passage of time and is therefore of little value in assessing the presence of congenital syphilis. In 1929, Lamez[10] confirmed the transitory positivity of the Wassermann reaction and asserted that should the reaction become negative in the first weeks of life and remain so, the child should be considered free of syphilis, provided he remains healthy. At about the same time, Dunham[3] showed that the disappearance of complement-binding substances can be measured quantitatively. It remained, finally, for Faber and Black,[4] and for Christie[1] to clarify the meaning of the positive complement fixation reaction in the infant's blood in the first few months of life by applying a quantitatively titered reaction as an accurate method of diagnosis.

The advantage of the quantitative over the routine qualitative test is that it provides a measure, on the one hand, of the decrease in titer of the circulating reagin, which has passed through the placenta, as it disappears from the blood of the infant; and, on the other, of the increase in titer of circulating reagin, should the infant be infected, and be elaborating its own reagin. From a series of quantitative determinations of reagin, it is possible to observe a trend in the behavior of this substance in the infant's blood. The tests will provide an indication of the source of reagin; whether it comes from the mother or from the infant. With this information, it is possible to arrive at an accurate diagnosis of congenital syphilis, as a rule within a period of three months after birth.

The risk of syphilis to the infant is proportional to the duration of infection in the pregnant woman (Kassowitz's law). The woman with active signs of primary or secondary syphilis is almost certain to infect her fetus; while the longer latency of disease endures, the less likely is she to transmit the infection to her offspring.

With the conventional methods of treatment, using metal chemotherapeutic agents, the best results for the fetus are obtained when treatment is begun early in pregnancy, that is to say, before the fifth month, and continued regularly to the termination of pregnancy. In a re-evaluation of the study, made several years ago, by McKelvey and Turner[12] on the effect of syphilis on pregnancy, Goodwin and Moore[6] have recently recalculated the original figures of these authors on the frequency of prenatal syphilis following various amounts of treatment. In the presence of early active syphilis in the mother, approximately 95 per cent of their infants almost certainly were infected when no treatment was given during pregnancy. Even when as much as 3 Gm. of arsphenamine were given, about 5 per cent were infected. It would seem also that the newer methods of intensive arsenical therapy with intravenous drip, or multiple syringe injection, in five to ten days, result in failure to protect the infant in approximately 15 per cent of cases.

On the basis of these figures, it seems that the best of the older methods of treatment, properly applied, fail to protect about 5 per cent of infants born of mothers in the primary or secondary stage of syphilis. When less adequately applied, from 30 to 50 per cent of the pregnancies end with congenitally syphilitic infants.

If the hazards and inconveniences to the mother of arsenical therapy are considered together with the amount of protection afforded the infant, the results in general of the older methods of treatment leave something to be desired.

My purpose in this paper is to call attention to the promise in penicillin therapy for the prevention of prenatal syphilis. The absence of toxic or other undesirable effects of this drug; the ease of, and the short time required for its administration are factors recommending the antibiotic agent. Should its potency as a measure for protection of

the fetus against syphilis approach that of older methods of treatment, it will at once become the treatment of choice.

From the observations thus far available, it would seem that metal chemotherapy may be abandoned in the future. On the basis of published reports and of experience not yet reported, penicillin has decreased the risk of infection to the infant beyond that expected from conventional methods of treatment.

Penicillin is given a crucial test when used during the primary or secondary stage of early syphilis. Left untreated under such circumstances, pregnant women at this stage of the disease would almost certainly give birth to syphilitic infants. Reports from the Johns Hopkins Hospital[6] and the University of Pennsylvania[8] show the satisfactory results in the infant when penicillin is employed under these conditions.

Sodium penicillin was administered intramuscularly in total doses of from 0.6 to 3.6 million units over a period of from eight to fifteen days. Single doses of 20,000 and 40,000 units were given every three hours. Following this treatment, there was but one fetal death in 61 pregnancies, and only one of 60 infants born alive and apparently normal later developed syphilis. This is a failure rate of 1.6 per cent. In the infant that treatment did not protect, the mother had developed a clinical relapse in the ninth month of pregnancy after receiving 1.2 million units of penicillin in the fifth month of gestation.

Further evidence of the efficacy of penicillin lay in the fact that approximately 20 per cent of the women were treated after the thirty-second week of pregnancy, and 54 per cent between the sixteenth and thirty-second weeks.

In the John Sealy Hospital of the University of Texas, 20 pregnant women have been treated with penicillin. Of these, 18 were in the primary or secondary stage of syphilis, and 2 in the period of early latency. Eight of the women in the early active stage of the disease were treated with a total of 0.6 or 1.2 million units of penicillin over a period of four and seven and one-half days, respectively. These have given birth to 9 infants. All have been observed for four months, and 5 of the infants have been under observation for seven months or longer. All remain normal. Two of the infants whose blood gave positive serologic reactions at birth had negative reactions at 4 and 7 months of age, respectively. One woman with secondary syphilis, who became pregnant near the time of treatment with 1.2 million units of penicillin, aborted in the seventh month of pregnancy, when her blood was still serologically positive.

If, as the number of cases increases, this degree of success continues, penicillin will have been unequaled in the prevention of prenatal syphilis by any other method of treatment. In this case the use of metal chemotherapeutic agents can be abandoned.

It is recommended, for the present, that in the treatment of women in pregnancy, sodium penicillin in physiological sodium chloride solution be given in doses of 20,000 units each every three hours to a total of 120 doses, or 2.4 million units. In the event of serological or clinical relapse this treatment should be repeated, as it also should in the presence of a persistently high serologic titer.

SUMMARY

The prevalence of syphilis in Texas makes the prevention of prenatal infection an important problem of public health. While older methods of treatment with metal chemotherapeutic agents protect the fetus in most cases if properly employed, penicillin promises to give even better protection. At present it is probably the treatment of choice for the pregnant woman. A total of 2.4 million units given in 120 injections of 20,000 units each over a period of fifteen days is recommended.

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The art and science of the practice of medicine is not complete without knowledge of the function of human personality and it is the duty of every practicing physician to acquire as much of this knowledge as possible.—Addison M. Duval, M. D., M. Ann. District of Columbia, Aug., 1946.

FROG TEST (XENOPUS LAEVIS) FOR PREGNANCY

C. B. SANDERS, M. D., F. A. C. P.
HOUSTON, TEXAS

L. Hogben, H. A. Schapiro, H. Zwarenstein, and C. W. Bellerly first experimented with the African claw frog from 1930 to 1934 in an attempt to use it as a test animal for pregnancy. Later in the United States, Abner I. Weisman, Christopher W. Coates, and their associates carried on experimental work with this frog to evaluate the method. The test is based on the original discovery of Ascheim and Zondek that gonadotropins will induce ovulation in animals such as immature white mice, rats, and rabbits.

In the frog test, female frogs, injected with concentrates of urine from pregnant women, will lay eggs within four to eighteen hours depending upon the amount of hormone present in the urine. The results of the test have been so excellent, and the method of running the test so simple and rapid, it appears that the test will be well worth using to supplant other animal tests used for the determination of pregnancy. The accuracy of the tests reported to date, where a large series have been carried out, is greater than 98 per cent. No false positive tests have been reported but the error occurs in false negatives when the patient has not been pregnant long enough to secrete sufficient gonadotropic hormone to give a positive reaction. In those cases reported as false negatives, the interval of pregnancy was usually less than ten days and when the tests were repeated later, positive results were obtained.

The African claw frog is imported from South Africa and is known as Xenopus Laevis. It lives entirely in water and only comes on land to feed. Before the frog can be used for pregnancy tests it must be examined and evaluated as to health and maturity.

In the laboratory, the frogs are kept in glass containers or tanks of water which are kept at approximately 70 F. They have to be fed ground beef heart or liver two or three times per week. The water must be changed before and after feeding and at other times when it gets dirty. The frog ovulates in darkness, therefore it should be injected late in the afternoon and kept over night for ovulation. After injection each frog is placed in a glass jar, in the bottom of which is placed a piece of hardware cloth raised from the bottom of the jar for a distance of approximately 1 inch, to prevent the frog from eating her own eggs after laying them. The jar should be covered with a mesh wire cover and weighed down so that the animal cannot escape.

The patient is advised to bring in the first specimen of urine which she voids on arising in the morning. Forty-five ml. of this urine is measured into a glass jar with a tight fitting screw top. The urine is acidified to a pH of 4 using 20 per cent hydrochloric acid and bromphenol blue as an indicator. To this acidified urine is added 5 ml. of a 20 per cent acid washed kaolin solution. The lid is then screwed on tight and the jar shaken in a shaking machine for ten minutes. Kaolin absorbs the hormone. The suspension is removed from the shaking machine and poured into a 50 ml. lusteroid centrifuge tube. It is then centrifuged for five minutes and the supernatant fluid is poured off. To the kaolin in the bottom of the tube is added 2 ml. of 10 normal sodium hydroxide which is mixed well with the kaolin and shaken. The specimen is again centrifuged and the supernatant fluid containing the hormone is poured into a smaller tube, acidified to a pH of 6, using 5 per cent hydrochloric acid and nitrazine paper as an indicator. There should be approximately 2 to 2.5 ml. of fluid containing the hormone for injection into the frog. Frogs should be selected which have bulging lungs and a purplish red cloaca since it is believed that these are the ones which have full egg sacs. The frog is removed from water by a net or with bare hands and is wrapped in a towel since it is slick and slimy and hard to hold. Injection is made into the dorsal lymph sac in the mid line approximately 10 mm. from the tip of the backbone. Injection should be made slowly so as not to cause a reversal of the lymph flow and thus invalidate the test. Care must be taken not to stick the needle into body cavities where it will puncture vital organs and kill the frog. If the specimen contains hormone the frog will begin to lay eggs within four to eighteen hours after injection. The frog should be kept in the dark and quiet while running the test since it has been shown that too much light will inhibit the laying of eggs. If at the end of eighteen hours the frog has not passed eggs, the test is negative. If the physician believes that the frog is not functioning right, he can follow up his original injection with an injection of a specimen known to contain hormone and the frog will lay eggs. If she does not lay eggs she should be discarded. It has been suggested that two frogs be injected for each test, which would be more reliable since each frog varies in sensitivity to the hormone. One frog should be kept for each

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test per month. Frogs which are injected with specimens not containing hormone should be rested for one week and then they can be used again. Frogs which lay eggs must have a rest period of one month before being used again. Frogs which have been recently fed should not be injected since they regurgitate their food and its presence in the water will obscure the eggs.

To date I have run 150 tests for pregnancy and have missed 2 cases in which the patient was pregnant and the animal did not lay eggs. Repeating the tests on these patients ten days to two weeks later gave positive results. I believe it is a simple, rapid, and accurate test at the present time and am enthusiastic about it.

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ABSTRACT OF DISCUSSION

Dr. Ellen D. Furey, Beaumont: Until a consistently accurate diagnostic test for early pregnancy is achieved there will continue to be dissatisfaction attendant upon any such test revealing even occasional irregular results. Dr. Sanders' experience with the frog test agrees with the majority of reports as to its high efficiency. One report in the January, 1946 *American Journal of Clinical Pathology* records only an 86 per cent accuracy. The concentration of the hormone apparently is a great factor in the success of the test. The standardization of the test animals likewise is an important factor. It is interesting to note that no false positives are reported.

I would like to know how the frog test has worked out in cases of ectopic pregnancy where the hormone concentration is usually low.

One must consider the rapidity and accuracy of the results as well as the lack of odor in the test animal as outweighing the problems of adequate housing of the frogs, the handling of slimy frogs, the care and experience necessary in proper injection, and the time required in concentrating the urine.

I wish to thank Dr. Sanders for presenting these useful data as a step along the way toward attaining the goal of a perfect test for the diagnosis of pregnancy, a test which combines accuracy of results with a degree of facility in performance.

Dr. John J. Andujar, Fort Worth: This presentation of the frog test for pregnancy is most complete, and Dr. Sanders deserves our thanks for giving us his valued experience. About ten years ago, an effort was made to popularize this test, but great difficulty was encountered in breeding these frogs in the United States. Apparently it required one or two years for them to mature sufficiently for clinical laboratory use, and the frogs were unable to propagate in adequate numbers. This made the test dependent on the fluctuations of the import trade, and I am wondering whether Dr. Sanders has been able to solve the problem of breeding the frogs in this country.

Dr. B. F. Stout, San Antonio: I would like to know how long it would take to prepare ten samples of urine as outlined by Dr. Sanders for injection of the frogs.

Dr. A. O. Severance, San Antonio: I should like to ask Dr. Sanders what is the size of the population of the frog colony which he finds necessary to maintain adequately to carry on the pregnancy test.

Dr. Sanders, closing: I have not had any experience in running the test in known cases of ectopic pregnancy. I do not raise the frogs but buy them from an importer. It does not take much more time to prepare ten samples of urine for injection than it does one sample using the standard method for preparing the specimens. As mentioned in the paper above there must be at least one frog for use per test per month and it has been suggested that two frogs per test per month would be better. During the coming year I hope to be able to run comparative tests using frogs and other accepted animals so that I may determine for myself the degree of accuracy of the test as compared with other standard animal tests for pregnancy. I wish to thank all the members of the section for their discussions and interest in the paper.

INTERSTITIAL IRRADIATION THERAPY IN CARCINOMA ORIGINATING AT THE LIMBUS

REPORT OF TWO CASES TREATED WITH RADIUM ELEMENT SEEDS

E. M. SYKES, M. D.
SAN ANTONIO, TEXAS

When irradiation as a therapeutic measure in malignant epibulbar tumors is considered, several factors are involved: first, the extent of the malignant infiltration; second, the necessary dosage lethal to tumor cells in the involved area; third, the importance of the required dosage not injuring intraocular structures, especially the lens; fourth, the method of application.

If the carcinoma is limited to the anterior part of the eyeball and has not invaded the globe, the orbit, or the lymphatics, radium therapy can be used successfully. The origin is usually at the limbus where there is a transition from the conjunctival epithelium to the corneal epithelium and a down growth of the cell process occurs at this point. Bowman's membrane and the sclera offering considerable resistance to the penetration of malignant processes, the tumor tends to spread laterally rather than invade the eyeball. This explains the tendency of the growth to stay localized for a long time, and undoubtedly has played an important role in the many successful results reported after using irradiation therapy.

Pack and Taber introduced into the United States the plan of uniform platinum-filtered radium seeds which Sluys, of Belgium, had first employed. In an article written in 1937 they stated, "Although we have found the sheath needles containing the platinum-filtered radium cells eminently satisfactory in most cases, there are occasional indications for the use of even shorter radium foci. This need was met in times past by the purchase of gold radon seeds. As a substitute, we planned the construction of a radium

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element seed which would constitute a permanent addition to the supply of radium and could be used repeatedly without appreciable loss in strength or value."

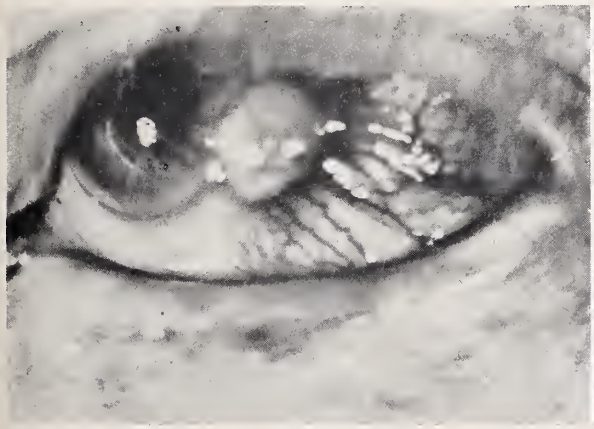
This seed is really a tiny tube with an eyelet of smooth bore at one extremity through which the thread for removal is inserted. The dimensions are as follows: over-all or external length, 7.50 mm.; active or internal length, 3.27 mm.; external diameter, 1.20 mm. The filtration or wall-thickness is 0.3 mm. of platinum (10 per cent iridium-platinum). The filtration value is therefore the same as for the ordinary gold or platinum radon seeds and the tables of dosage computed for the latter are equally applicable in the case of the radium element seed. The wall thickness of 0.3 mm. platinum is sufficient to filter out 97 per cent of the hard beta rays while 97.6 per cent of the gamma rays are emitted. The soft beta rays are totally absorbed. Favorable experience with interstitial irradiation encouraged utilization of a similar procedure in certain malignant tumors of the eyeball.

The proper dosage lethal to a cancerous growth within a given area can be fairly accurately estimated in the interstitial application of the radium element. By virtue of the inverse square law, the intensity of radiation at a given point is much greater on contact with the involved area than when the target-skin distance is 5 to 50 cm.

As beta rays are less penetrating than gamma, theoretically they seem more suitable for application near the lens. However, it is found by experience that gamma radiation, if delivered from a small point source, does not produce a reaction unfavorable to intraocular structures. Most of the cataracts from radiation have resulted after large doses of roentgen-rays or radium without adequate protection having been provided. This is especially so when the lesion is rather extensive and requires a large point source to produce the desired effect on malignant tissues.

If the progress of the disease is not halted, loss of vision and even death can result. Therefore, radiation therapy must be limited to malignant processes which have not invaded the eyeball or which have not progressed beyond the equator of the eyeball or into the orbit, if preservation of the eyeball and vision is under consideration.

The 2 cases reported in this paper were subjected to the interstitial application of radium element seeds containing 1.33 mg. These seeds were inserted in pockets made between the sclera and conjunctiva and sutured in place. They were left in situ for a definite length of time, depending on the size of the lesion. The rapidly diminishing intensity of the gamma rays, according to the inverse square law, insures minimum effect on distant normal structures with maximum effect on the tumor and tissue adjacent to the radium seed. The dosage used in the cases reported was estimated by Dr. Asa Beach.



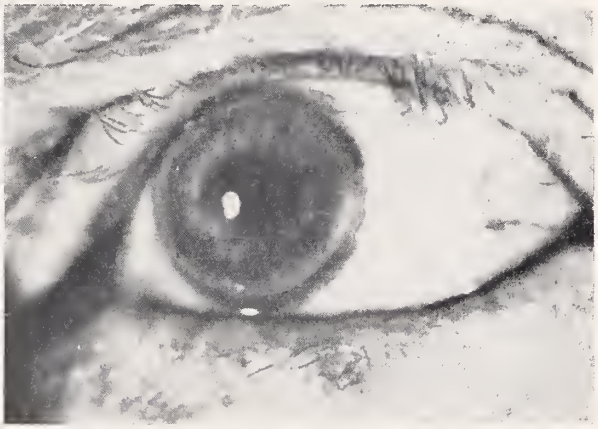


FIG. 1. (Left) CASE 1. Original appearance of limbal tumor squamous cell epithelioma, grade 2, Broders.

(Right) CASE 1. Appearance five years after excision and interstitial application of two radium element seeds.

Various methods of applying roentgen-ray and radium therapy to tumors of the cornea and conjunctiva have been devised and according to many reports have been used successfully. (See references.)

CASE REPORTS

CASE 1.—H. E. R., a white man, age 62, whose occupation was a watchman, about December 1, 1940, first experienced a burning and stinging sensation in the left eye. He noticed a small gray tumor near the cornea on the temporal side. This tumor grew rapidly and six weeks later the patient sought medical advice.

His family history was negative, with no history of cancer.

On January 11, 1941, an examination of the left

eye revealed a firm, adherent, grayish, oval-shaped tumor 6 by 4 mm. and 3 mm. thick, located at the limbus at about 3:30 o'clock. Vascularization was plentiful. Intraocular examination of the left eye revealed that the lens had a few small spoke-like opacities; the fundus was normal. Vision was 20/30 in the left eye. The right eye was apparently normal with vision 20/20.

On January 14, the growth was removed under local anesthesia with a diathermic surgical needle. The base on the cornea and sclera was also touched with the high frequency cautery. The resulting exposed scleral area was covered with a conjunctival plastic.

A pathological report from A. O. Severance of the Nix Hospital Laboratory, was as follows:

"*Gross.*—The specimen consists of a small oval bit of tissue 6 mm. in its greatest diameter and 3 mm. thick. In the center there is a raised, slightly brownish tumor. Grossly the tumor appears adequately excised.

"*Microscopic.*—The section shows tumor cells arranged in broad anastomosing sheets, and large and small masses which show considerable keratinization and intercellular bridges. The individual cells vary considerably in size and shape; some are tumor giant cells; all have eosinophilic, finely granular cytoplasm and round to oval vesicular nuclei with large nucleoli. Mitotic figures are quite frequent. Some are atypical. Mitoses vary from 0 to 3 per high power field, and average less than 1. A few epithelial pearls are seen. The tumor extends to the edge of the incision on both sides and the base in several sections. The tumor is in contact with the overlying epidermis and has replaced it in the center. A few inflammatory cells are seen in the stroma. This is a grade 2 (Broders) squamous cell epithelioma."

Since it was impossible to tell whether or not cells had invaded the sclerotic trabeculae, perivascular, or perineural spaces, radiation was considered advisable.

On January 21, two radium element seeds of 1.33 mg. strength were inserted under the conjunctiva and held in place by sutures. The reaction was most satisfactory. It was so calculated that the patient received 128 mg. hours of gamma irradiation on an area of 0.9 cc. Although five years have elapsed there has been no recurrence of the epithelioma. During the last six months the lenticular opacities have increased with a resulting diminution of vision to 20/100 corrected to 20/40 by a minus 4.00 lens. This increase of lenticular clouding could hardly be caused by exposure to radium emanations four and a half years previously, especially since some opacities were present prior to irradiation.

Case 2.—F. H., a white man, age 60, was hit in the left eye during a fight twenty-three years ago. A few years later this eye began to get red and a tumor was noticed growing on the eyeball. About eight years ago he went to the Robert B. Green Hospital and had a pterygium removed from the left eye. A year later the pterygium returned and was removed again "by an electric needle." A few months later the pterygium had returned again. The eye remained red and the tumor gradually grew larger. He then consulted another doctor who told him that the growth appeared to be of a cancerous nature and advised the removal of the eyeball. The vision had always been poor in the left eye.

His family history revealed that one brother died of cancer of the lung, one sister died of cancer of the stomach, and a nephew died of cancer of the lung. The patient himself had had no particularly severe illnesses. He had always smoked excessively.

Upon examination March 27, 1944, a rather firm semi-transparent growth was seen growing over the cornea in a pterygium-like manner and extending opposite to the pupillary border. There was also considerable thickness and redness of the conjunctiva which extended over an area 1 by 2 cm. This area was elevated about 1 mm., was firm to the touch, and adherent to the sclera. The preauricular gland was not enlarged. A small section of the pterygium-like mass was removed and sectioned. Right eye vision was 20/20. Left eye vision was 20/40 (corneal scars). The fundi were apparently normal.

Dr. Severance reported as follows:

"The sections show tumor cells arranged in small to medium sized masses and surrounded by a small amount of fibrous connective tissue. The latter contains a moderate number of inflammatory cells, particularly round cells. The tumor contains frequent epithelial pearls and it is very well keratinized. Intercellular bridges are readily made out. The individual tumor cells vary moderately in size and shape, have eosinophilic granular cytoplasm, and have round or oval moderately chromatic or vesicular nuclei. Some of the nuclei have large prominent nucleoli. There are a few large hyperchromatic nuclei. Mitotic figures are infrequent. This tumor is a well differentiated squamous cell epithelioma. I believe it would fit Broders' classification of grade 1."

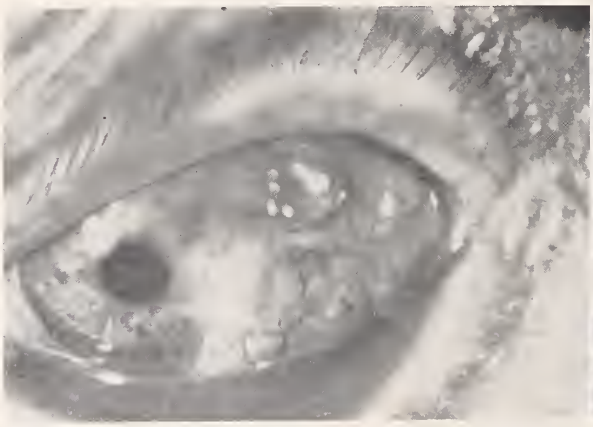


Fig 2. (Left) Case 2. Diffuse carcinomatous infiltration of the conjunctiva. Squamous cell epithelioma grade 1, Broders.

(Right) Case 2. Appearance one year after irradiation. There is corneal scarring and conjunctival thickness, but no return of the epithelioma is apparent.

Although this type of tumor is not considered radio sensitive, it was thought feasible to radiate the area involved with radium seeds. Four radium element seeds of 1.33 mg. strength were implanted between the sclera and the conjunctiva. The sutures holding the needles were tucked behind the lid at the outer canthus, the eye being bandaged firmly to hold the lids together. The area was irradiated for a period of forty-eight hours, the dosage being 250 mg. hours.

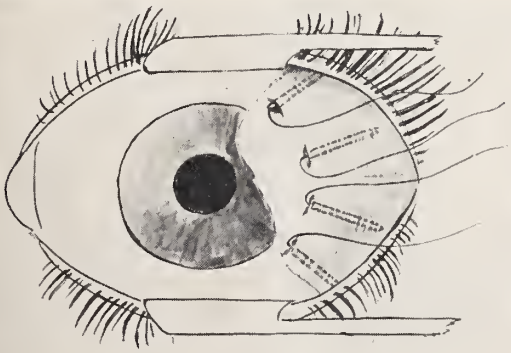


Fig. 3. Diagrammatic sketch showing subconjunctival application of radium element seeds.

One year has elapsed since irradiation and no return of the growth has occurred. There has been no reduction in vision nor has any lenticular clouding in the left eye been observed. A cure cannot be claimed in this case because the minimum time limit of five years has not been complied with.

CONCLUSIONS

The interstitial application of radium element seeds to primary malignant tumors originating at and limited to the anterior surface of the eyeball has certain definite advantages over other methods of irradiation. However, the patient should be hospitalized and supervised during the time the radium is left in situ. Two cases of carcinoma originating at the limbus, as described above, were subjected to interstitial radium element therapy with apparently successful results.

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ABSTRACT OF DISCUSSIONS

Dr. C. M. Griswold, Houston: I desire to compliment Dr. Sykes on his timely paper and the good results he has obtained.

From a diagnostic standpoint let me emphasize that any isolated, elevated growth at or near the limbus with a white leukoplakic surface should be considered epithelioma and treated as such.

There are essential technical differences in the use of radiotherapy in malignant growths of the orbit as compared with other structures of the body in which these agents are in widespread use. The problem of dosage is most important. Radiotherapy, in the average case of cancer, is not conservative, and a degree of fibrosis at the site of the growth is of minor importance, but the reverse is true in lesions of the eye. The lesions are, as a rule, well localized and extreme conservation of the normal structures is of paramount importance. Fortunately, cancer of the eyeball responds in a satisfactory manner to a relatively small amount of radiation as compared with the amounts required to treat carcinoma elsewhere; consequently, complicating fibrosis is minimal and full use of the eye is the usual outcome.

In 30 cases of primary carcinoma of the conjunctiva which I have treated a technique has gradually been developed of "small dose treatment." Equally good results have been obtained with heavier doses of radium than are now advocated. In fact, 10 of the patients in the 30 under scrutiny received an average of approximately 250 mg. hours of gamma radiation at a distance of .5 inch. The 20 patients receiving the small dose treatment averaged 45 mg. hours of beta radiation with equally satisfactory results.

The technique used in all of my cases is as follows:

The patient is placed on his back with a pillow under his head for comfort. The eye is anesthetized with 2 drops of butyn and the lids are retracted with spring lid retractors. Three or four monel metal steel needles, each containing 5 mg. of radium, are placed in a horizontal position 1 mm. apart on a strip of Scotch tape. A thin rubber dam covers the Scotch tape on the side next to the eye and a strip of adhesive tape is attached to the radium needles outwardly and extends vertically so as to attach itself to the upper and lower lids. This holds the radium in position and the adhesive tape is carefully attached to the lids so that the radium plaque lightly or almost touches the lesion.

The problem of immobilizing the eye is satisfactorily managed by having the patient focus at a fixed point on the opposite wall. The radium is left in place forty minutes at a time. Usually four such exposures are given at daily intervals. A drop of butyn is instilled in the eye two or three times during the exposure and every three or four minutes the eye is flushed with 2 per cent boric acid solution to counteract dryness. These instillations do not disturb the position of the radium and the patient never complains of real discomfort.

Within three or four days after the radium therapy has been completed the tumor and adjacent conjunctiva begin to show congestion and this reaction to the radium rays increases in intensity until the twelfth or fourteenth day. Resolution then begins and by the time six weeks have passed there is little conjunctivitis present. No iritis has been noticed. In 1 case where glaucoma existed there was a marked flare-up of this condition which eventually subsided.

The patient is advised to wash the eye several times daily with 2 per cent boric acid solution following treatment.

After the reaction from the radium has cleared, no sign of tumor remains. The conjunctiva at the site treated is somewhat thinner, less vascular, and smoother than the adjacent tissue. So far as we can learn, there has never been a local recurrence.

In 1 case metastasis to the preauricular node on the same side of the face occurred, but this case was the one where the original lesion was situated below the inferior limbus and had been surgically removed twice before receiving radium.

The good results obtained in these cases are largely due to the fact that they are seen and treated early.

Dr. Malcolm K. McCullough, Dallas: Primary epithelioma of the conjunctiva occurs most commonly at the limbus or zone of epithelial transition. These tumors are fortunately rather rare and are identical in structure with that of squamous epitheliomata elsewhere, though basal cell carcinoma has been reported as arising in this same location. Duke Elder states that on the whole, in comparison with carcinomata elsewhere, these tumors are relatively mildly malignant, in that they continue to be superficial for a long period of time. He states that the attachment to the globe may be small and that extension outward is much more rapid than inward, due to the resistance of the cornea and sclera, both of which are deficient in lymphatics. They are slow growing and are not prone to invade the neighboring lymph glands. Extension of the growth may occur superficially over the cornea and sclera or the interior of the eye may be invaded through the cornea or through Schlemm's canal.

The treatment of carcinoma of the limbus is the same as that of malignancy elsewhere, surgical removal followed by radium or roentgen therapy. Since these tumors are not highly malignant and do not tend to metastasize early, the small ones should be removed and treated with radium as described by Dr. Sykes. However, if the growth is extensive, the globe should be removed and possibly the orbital contents as well.

We are deeply indebted to Dr. Sykes for his able presentation and commend him for his skill in handling the cases reported.

TRAINEESHIPS IN CANCER OFFERED

The National Cancer Institute, Bethesda, Md., will award between seventy-five and one hundred traineeships in the diagnosis and treatment of cancer during the fiscal year from July 1, 1946, to June 30, 1947, according to *The Journal of the American Medical Association*. A stipend of from $2,500 to $3,000 per year is available to accepted physicians. Minimum requirements are graduation from an approved medical school and one year internship in a hospital approved by the American Medical Association. Applicants must be under 40 years of age and be acceptable to the institution selected for training, with which they must make their own arrangements. Appointments, originally for one year, may be extended to a maximum of three years. Additional information may be secured from the National Cancer Institute.

ETIOLOGY OF OTOMYCOSIS

AN EXPERIMENTAL STUDY

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and
J. M. ROBISON, M. D.
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Forty cases of otomycosis were studied clinically and mycologically for evidence on etiology. Most of them were seen in the outclinic, the rest in the private practice of Galveston physicians. Clinical data were recorded on each diagnosed case and a specimen of exudate sent to the mycological laboratory. There cultures were made and, where the quantity of material sufficed, a direct microscopic examination.

The condition is of limited geographic occurrence, but in tropical and subtropical climates it may constitute a major problem of otology. Ingram,[12] in Florida, and Trexler,[19] in Hawaii, stated that the incidence is heaviest in very warm climates and near the seacoast. Some feel that fungi might occur more widely than is recognized in the otitis externa of more temperate zones. Simms[17] quoted Siebenman to the effect that 1 per cent of all disease of the external ear in Germany is due to aspergilli.

Reported incidence in the United States is greatest in Florida (Gable[6]). The condition is frequently encountered in Galveston, where climatic conditions in many respects approximate those of Florida. We are told that practitioners upstate in Texas do not often find it. Amstutz,[1] reporting a case in Ohio, said that otologists of wide experience in that part of the country had not found and recognized a case.

Cases continue to occur throughout the year, though higher summer incidence is mentioned by Gill.[7] Causative influences such as swimming have certain seasonal tendency. Age, sex, or race exert no significant influence apart from an infrequency in children. Only 1 of our patients was a child, and otherwise the occurrence accorded roughly with age, sex, and race distribution of the clinic patient population.

Nearly all of our culturally positive cases yielded either A. niger or A. flavus, the former with about twice the frequency of the latter. Aspergillus was present so prolifically as to be demonstrable on direct microscopic examination as well. The mycology of otomycosis has been of similar pattern elsewhere. Tabulation of literature from various parts of the world indicates in seven reports the finding of these same two organisms, in

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another seven the A. niger only, in three aspergilli unspecified as to species, in one A. fumigatus, and in one a trichophyton.

Other saprophytic molds occurred now and then in our series, though rarely so prolifically as to show in the direct microscopic preparation. Once the scopulariopsis appeared in microscopic preparation and culture, and once again in culture only. Incidental fungi found in culture alone include penicillium, actinomyces, and another aspergillus, A. glaucus. Workers elsewhere mention similarly the incidental presence of A. sydowi, A. albus, A. nidulans, and species of penicillium, mucor, yeast, alternaria, trichophyton, mycotoruloides, monosporium, monilia, hormodendrum, actinomyces, and achorion.

Fungus involvement of the external ear has long been recognized. Mayer[13] reported finding aspergillus in an infected ear canal as early as 1844. Otomycosis usually has been considered a clinical rather than mycologic entity, for to a large extent it has to be diagnosed without mycologic laboratory findings.

Pronounced cases produce a plug of exudate that resembles wet, macerated newspaper pulp, filling the depths of the canal. From this exudate the fungus may be recovered, and in some instances the plug itself is visibly moldy and covered with black spores. Less typical cases do not display enough exfoliation to produce these features, and resemble scaling or weeping eczematoid lesions.

Comparing the severity of the lesion with fungus recoveries therefrom, we found that the fully developed clinical picture coincided in large degree with the positive mycologic picture. Cases that presented the typical symptoms with pulplike plug yielded cultures of A. niger or A. flavus, and the mold occurred so prolifically as to appear in direct microscopic preparation. Where material was sufficient to make a microscopic mount, the aspergillus structure appeared in all cases from which either of these fungi was recovered culturally. The culturally negative cases always presented negative microscopic findings.

In 9 cases in which cultures were positive for the A. niger, 5 had the characteristic clinical picture just mentioned, and the other 4 were not so described in the record as to show. Of 5 cases similarly positive for A. flavus, 3 were so described as to bring out this point and all 3 presented this picture. One with a mixture of both organisms showed the same. Of 20 cases that were culturally negative, 2 had been described as having this characteristic pulpy plug of exudate and 12 as lacking it. The others were not so described as to indicate or else were of questionable diagnosis.

Inasmuch as the fungus is richly and uniformly present in cases with the characteristic mass of pulplike exudate, and is not demonstrable in cases without it, it may be concluded that the fungus is itself responsible for this thick exudate. The matter is largely mold mycelium mixed with loose epithelial matter. From clinical appearances one gets the impression that the mycelium roots itself into the affected skin and rolls up epithelial tissue, which mixes with the discharged fluids and comes out in sodden masses. This accumulation leads to the more pronounced symptoms of the disease. Roosa[15] in 1870 expressed his belief that while other disease precedes, the formation of vegetable fungus in the ear leads to the symptoms that bring the patient to the physician.

Some factors that favor this prolific multiplication of fungus are evident. Water in the ear has been found responsible in some instances. We got the history repeatedly of recent swimming in the Gulf. The water may have planted mold spores, or it may have softened the tissue or surface secretions to support growth. Gordon[9] described an outbreak of otitis near Gatun Lake, Canal Zone, in which A. niger and A. flavus were identified. He regarded the wetting of the auditory canal by swimming as the principal predisposing factor, and after swimming in the lake was prohibited he encountered no new cases.

A contributing factor mentioned by Gill[7] and others is a lack of cerumen in the affected ear. We ourselves have noted this with some regularity. Cases of otomycosis exhibit a scantiness of cerumen, resulting from atrophy of ceruminous glands or the washing away of cerumen by persons cleaning their ears or by swimming. We have found that cerumen itself has definitely protective properties and can be utilized to relieve irritation in the canal.

The possibility occurred to us that cerumen might exert a fungistatic effect, retarding growth of fungi on the epithelium. We conducted a series of experiments in which cerumen was added to culture media. Concentrations varying up to 10 per cent in Sabouraud's agar failed to affect the growth thereon of aspergilli. In other experiments the inoculated spores were variously exposed to cerumen, and this did not in any case materially retard growth. The favorable influence of cerumen evidently is not fungistatic. A mechanical or otherwise protective influence may be exerted on the epithelium.

What we have known as otomycosis does not regularly present the clinical and myco-

logical findings just described. It did in only about a third of our cases. A milder form fails to exhibit this degree of exfoliation or in most cases the actual evidences of mycosis. It is spoken of as otomycosis because of a presumed association with fungus growth. The lesion without characteristic clinical and mycologic manifestations has been regarded as an earlier stage with all fungus elements buried in the epithelium and not discharged into the exudate taken for specimens. Failure to isolate fungi or other organisms hidden in the depths of inflamed tissue is common experience.

A different view is that conditions of other causation sustain the growth of fungi whose spores happen into their discharge. Chisholm and Sutton[4] spoke of the disease as secondary to pathologic conditions involving maceration of skin, eczema, furunculosis, or chronic discharge. A case of ours supports this conception by yielding different fungi at different periods. It is not likely that assorted fungi could invade the skin to initiate a lesion, and then so proliferate as to make themselves apparent only one at a time.

For several years this patient presented an eczematoid lesion of the ears, first weeping and later dry and scaling. Culture for fungi was negative. Itching persisted and an urge to probe the ear canal. As time passed a sense of fullness developed and hearing was impaired. A plug of exudate was removed from which culture and direct microscopic examination were positive for a species of scopulariopsis. Under treatment the condition cleared up. Over a year later the ear canal again filled up. Similar examination was made and A. flavus was isolated, with microscopic examination positive for aspergillus. Treatment was administered with subsequent disappearance of the fungus and without recurrence to date. Unless this were a sequence of different conditions, it must have been a lesion of other than mycotic origin which became contaminated with one fungus after another and thereupon assumed clinical manifestations typical of otomycosis.

Just what damage the body suffers from the presence of these fungi is not clear. Bristow[2] thought that the disease may consist in mechanical obstruction only, due to plugging of the external canal with mycelium. He cited a suggestion of Wiedman that the fungi might be ranked as pathogens if they cause only an obstructive impairment to function.

Gable[6] suggested penetration of deeper tissue through toxic or other irritative properties. Oshima and Church[14] described proteolytic enzymes of aspergilli which can digest native proteins. Possible influence of toxin finds repeated mention in the literature. Henrici[11] described such a toxin, which we have demonstrated in A. niger and A. flavus. These toxic and otherwise deleterious substances have not been shown to take part in the inflammatory process.

Some, including Gill,[8] Hatch and Row,[10] and Whalen,[20] think the pathogenic mechanism to be an outright infectivity. A. niger, A. flavus, or whatever fungus it may be, is presumed to invade the tissue and produce disease. The cases without demonstrable mycelial overgrowth are thought of as infected by a hidden fungus. The fungus is regarded to be infective for such host as other agents make susceptible, even if not an outright parasite.

Evidence for this hypothesis consists in the frequency with which the respective fungi are found, and in the fact that the disease yields to fungicidal therapy. Various fungicidal agents have been used for local application. Chisholm and Sutton[4] gave potassium iodide internally as well, but few others have found this of advantage. While our mycologic findings and therapeutic results accord with those of the supporters of this view, we are not convinced of such significance.

Our cases yielded well to treatment with preparations containing fungicides. Some cases of the series were treated with thymol in 1 per cent alcoholic solution and others with gentian violet in 2 per cent alcoholic solution; we prefer the latter as it is less irritating. Results were good both in cases having heavy fungus growth in the ear and in those without demonstrable presence of fungi. The efficacy of gentian violet in the treatment of fungus infections has been amply demonstrated, among others by two of us (Spiller, Sharp, and John[18]).

This therapeutic evidence would argue well for the condition's mycologic basis if the only action of the successful treatments were fungicidal, but most local applications so employed have other activity as well. While employed here to bring about exfoliation and removal of fungus elements in the depths of the epithelium, they are recognized to be effective too for the cure of nonmycotic lesions.

Such is our experience with gentian violet. Various inflammatory conditions of the external auditory canal, including recurrent furunculosis, yield to this application. We first tried it under the assumption that these conditions might be associated with persistent mycosis. Itching, scratching, and consequent secondary infection of the skin could well result from fungus infection. On the other hand, gentian violet is effective also for the treatment of bacterial infections

(Burke, Jessup, and Phillips[3]) as well as other inflammatory conditions. We do not feel that the efficacy of such treatment actually proves a great deal regarding the etiology of otomycosis.

The sort of evidence recognized as actual proof of a causal relationship is wanting. A recovered fungus has not afterward been made to reproduce the lesion in healthy tissue, nor is the same fungus regularly recovered. The several different fungi that have been recovered occur abundantly in nature as saprophytes, and there is no compelling reason to think that their sustenance in the exudate of otomycosis is not saprophytic.

There are familiar instances in which saprophytic organisms find conditions under which they may become infective. This occurs notably about traumatized skin. Enlows[5] believed the fungi are capable of attacking the epithelium of the ear but that trauma is necessary for the initial lesion.

Another situation, familiar among the bacteria, is that in which peculiarly pathogenic types exist within a saprophytic species. Strains of a serologically distinguishable group acquire invasive properties unknown to the rest. The existence of specially invasive otomycosis strains among the aspergilli would go far toward explaining their pathogenicity. By methods previously described by one of us (Sharp[16]) we explored that possibility. This method of approach was not especially promising, as serologic relationships among the higher fungi are broad and antigens are not highly differentiative.

So far as available antigenic preparations could discriminate, it appears that otomycosis strains were not a more closely related group than unselected strains of the species as a whole, whether of A. niger or A. flavus.

CONCLUSIONS

1. The fungi associated with otomycosis are ordinary saprophytes such as occur on the normal skin, usually though not always Aspergillus niger, or A. flavus. In localities where they abound, and under circumstances favorable to the germination of spores that gain entrance, these fungi may proliferate in the auditory canal.

2. Excessive proliferation there leads to the highly characteristic signs of otomycosis. A plug of thick pulplike exudate forms, which consists largely of exfoliated epithelium and fungus mycelium. This characteristic development may be regarded as a complication of prior pathologic conditions not shown to be mycotic.

3. The external auditory canal does not favor excessive fungus multiplication when normal, but only when its physiology is altered. Such alteration occurs because of discharge from the middle ear in acute or chronic otitis media, removal or lack of formation of cerumen, or changes in the anatomical structure such as follow injury or reconstruction in radical mastoid operations.

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ABSTRACT OF DISCUSSION

Dr. James B. Nail, Wichita Falls: The authors' scientific investigation and report on this subject has been most interesting and instructive. It has been my practice to make smears of all suspected fungus cases, and information given by the authors on this subject explains why patients with clinical appearance of fungus infections upon whom negative smears were found recovered by fungus therapy. Cultures on these patients would most likely have demonstrated the fungi.

Their report of the etiology is most logical. A pre-existing otitis with infection or irritation followed by trauma had never occurred to me. I have confirmed the authors' theory and found it correct by further questioning some of my patients after perusing their paper, which I received a few weeks ago.

It was interesting to note their observation that persons with abundance of cerumen were seldom afflicted with mycotic ear infections, and that preparations made from cerumen had no value as a therapeutic agent. In my experience 2 per cent Sulzberger's iodine powder has been a satisfactory therapeutic agent for aural mycosis. After removal of every particle of exfoliation and crust from the external auditory canal with cotton applications saturated with hydrogen peroxide, the canal is dried and the powder liberally insufflated into the ear. This treatment is repeated daily or every other day. If the fungus infection is complicated by an eczematous condition, 6 per cent lenigallol zinc ointment is smeared into the canal before the powder is insufflated.

Cultures and smears were made from 2 patients

with clinical appearance and symptoms of otitic mycosis. Both showed Aspergillus niger. After five days a heavy growth covered the media (Sabouraud's). At this time 2 per cent Sulzberger's iodine powder was liberally dusted over the surface of the growths in each culture tube and the procedure repeated in twenty-four and again in forty-eight hours. (Perforated corks were used in tubes to permit aeration.) The day following the last insufflation of the powder in the tube practically all appearance of the growth on the media had disappeared and smears made from the growths showed no fungi present.

I am not in position to comment upon the authors' suggested therapy of gentian violet as I have not had sufficient experience with it; however, I fully anticipate the therapy they suggest to prove quite as satisfactory as their valuable contribution regarding the etiology, and I am confident their suggestions will be a great assistance to us in dealing with mycotic infections of the ear.

EXTERNAL OTITIS

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The external otitis patient forms a large percentage of an otological practice in the southern states. I say in the southern states for the reason that I once practiced in a northern city where there was a submarine base and almost without exception the few cases of external otitis I saw were in men who had recently been in southern waters in connection with their naval duties or, if the patient was a woman or child, in a navy family which had recently been in southern waters—usually the Caribbean region. That fact, plus the higher percentage of external otitis patients seen in the warmer climate, convinces me that geography plays a leading role in this condition. It is not only the temperature of the air but it is as much the result of the temperature of the water. The next most important factor is the absence of cerumen in the external canal. It is rarely the case for external otitis to develop in face of normal cerumen in the ear canal. This loss of cerumen usually comes about through repeated mechanical cleansing of the ear canal.

I have often thought that the cerumen glands may be destroyed by an active fungus infection of the canal, for on a few occasions I have seen young children who had an excess of cerumen develop an active fungus infection with edema of the canal wall, that is, the often seen black-white fuzzy fungus, and then after that was cleared up there was no return of cerumen. Another factor of importance is the wearing of headsets and head dresses that prevent the proper ventilation of the canal. This is seen in men who wear radio headsets and earphones and the Sisters of Charity. The ear canal being warm, dark, and moist makes it an ideal culture tube.

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The procedure of development of external otitis is usually as follows: First, a fungus infection occurs which acts to destroy the cerumen glands in the ear if there is much edema and swelling of the canal wall. The fungus infection is cleared up. The skin of the canal is dry and scaly because of absence of the cerumen. This results in an itching sensation and the patient scratches the canal —men usually using a match and women a bobby pin. This external trauma breaks the epidermal layer, and the external otitis is thus started. What organism, if any, is responsible I do not know. I have run cultures and smears on quite a few cases and the most constant organism in my smears has been a gram-negative bacillus, probably the Bacillus pyocyaneus. Often there is a gram-positive diplococcus or a monococcus. Rarely is there a mycelial thread or yeast organism. The more liquid the discharge or drainage the less likely is there to be a fungus type of organism present.

The types of this condition include first, the fungus ear. This ear itches and usually feels full. There may or may not be cerumen present. The fungi responsible may be the Aspergillus niger or funigatus or the white mucor corymbifer or monilia. If the patient has produced a reaction of edema and soreness of the canal wall through his scratching activities, I pack the canal with a strip of gauze about .25 inch in width and 2 inches long. This is packed in after thoroughly syringing the ear, cleaning it out, and thoroughly drying it. The patient is given a prescription for Burow's solution and instructed to keep the gauze wet with the solution by dropping 4 or 5 drops on the gauze every two hours and to return in four days. By then the edema and soreness has left and the canal is open. The canal is thoroughly cleansed again and dried and gentian violet applied. The canal is dried by blowing compressed air into the canal and then sulfanilamide powder is blown into the canal, as much for the drying effect as anything else. In fungus cases without painful canals I do not use the gauze and Burow's solution but only the cleansing and drying procedure plus the gentian violet and sulfanilamide powder.

The acute desquamative external otitis is usually bacterial in origin and the canal is filled with a soupy, sometimes greenish material. One must be sure and eliminate a perforated tympanic membrane in these cases. The skin of the canal wall is often edematous and acutely inflamed and some auricular adenitis may be present. The dermatitis may extend over the entire auricle and the temperature may be around 100 F. The patient is often in much pain besides his mental worry over a possibility of a surgical mas-

toid condition. Such a case is often bordering on a complication developing from the otitis such as erysipelas, furunculosis, or a chondritis of the ear. Treatment usually followed in the acute desquamative otitis is to cleanse the ear followed by swabbing the canal with merthiolate or 2 per cent mercurochrome. Then the canal is packed with a small gauze wick kept wet with Burow's solution every two hours by the patient. A prescription is given for an ointment consisting of ichthyol 1 dram, salicylic acid grains 10, zinc oxide grains 30, put up in 1 ounce of rose water ointment. Also a prescription for analgesic tablets is given. The gauze wick is allowed to remain in the canal for five days after which the canal has opened up and the pain has ceased. From then on I keep the canal cleansed, apply merthiolate locally, and have the patient use the ointment at night in the canal and on the affected part of the auricle.

The chronic desquamative external otitis is the most difficult of all to handle. The ointment named in the above paragraph has been of more help to me in this chronic form than any other single type of treatment. The chronic form is often a follow-up of the acute form. I do not recall ever seeing a chronic desquamative otitis which had normal cerumen in the ear canal. Among the things I have found of value in treating these chronic forms is the roentgen ray, sunlight, low carbohydrate diet, keeping the hands in gloves at night to prevent scratching the ears, and above all keeping water away from them. Many of the chronic forms will have periods of acute exacerbation in which treatment for the acute form is followed. When this acute exacerbation occurs it at times spreads under the tragus of the ear, into the postauricular fold, and may get into the groin region and other parts of the body.

Complications from external otitis consist of furunculosis for which cleansing and sterilizing the canal followed by gauze pack kept wet with Burow's solution is the treatment of choice in most cases. Sometimes one is called on to differentiate a furunculosis of the canal from an acute mastoiditis. If one is unable to see the tympanic membrane, this is more difficult to do, especially in children. The main point to remember is that the pain is produced by auricular movement in case of furunculosis, while in acute mastoiditis precise pressure over the tip of the mastoid, being careful not to touch or move the auricle, produces tenderness or pain. A diffuse chondritis of the auricle may result in a cauliflower ear but timely treatment with chemotheropy and wet Burow's packs will usually prevent the disfiguring result. Erysipelas is not an infrequent complication and I have found sulfadiazine to be much superior to penicillin in clearing it up. Exfoliation of the canal to the extent of denuding the bony wall may result and produce an atresia of the canal requiring a plastic repair.

In elderly people one must be on the lookout for a squamous cell carcinoma developing in an external otitis. I recently saw one that developed in a patient while under treatment for the otitis.

In closing I would like to stress first the importance of thoroughly cleansing the ear canal when treating these cases of external otitis. There is quite a sizable recess or pocket next to the tympanic membrane where the canal dips down to meet it, creating a difficult hole to clean out, but this must be done if there is to be success in treating these ears. One must irrigate them to get this pocket cleaned out. Second, the canal must be thoroughly dried out and blowing compressed air in the canal is about the best way I know of to do it. Third, I want to recommend the ointment I mentioned. The formula came from St. Clair Thompson's formulary and it has been exceedingly helpful in almost all forms of external otitis.

Capital National Bank Bldg.

ABSTRACT OF DISCUSSION

Dr. John H. Foster, Eagle Lake: Like almost everyone who has practiced in the north before coming to Texas, Dr. Robison is impressed by the great prevalence of external otitis in this climate. Just how much this is due to the incidence of fungus infection I am not prepared to say, but it undoubtedly plays an important part. The whole thing constitutes a vicious cycle and one is apt to be led into error as to which is cause and which effect. For instance, as an after effect of otomycosis, there may be a dry, scaly condition of the ear canal that favors infection. On the other hand fungus infection does not attack a canal that is properly protected by a coating of cerumen. In a dry canal infection by otomycosis is fairly easily killed, but if the canal remains unprotected by wax, it is only a question of time until there will be reinfection.

What produces a dry condition of the ear canals varies in different people. I have seen tiny infants in whom all their life the wax in the ears has been hard and has had to be removed mechanically, and when cleaned the canals were dry and scaly. These cases resemble the skin condition due to some food allergy, and may be due to that cause.

The most common error into which physicians are prone to fall in the consideration of this subject, both as to etiology and treatment, is to look upon external otitis as a disease entity, whereas it really comprises a number of different conditions. I should suggest that a classification something like the following be used:

1. Acute otitis externa.
   a. Acute mycotic infection.
   b. Acute eczema.
   c. Acute pyogenic infection, localized and diffuse.

Of course the case may be complicated by a combination of these. For instance, an acute fungus infection may, and often does, become complicated by a pyogenic infection caused by scratching. Likewise,

an acute eczema may become infected with streptococci and become erysipelas.

2. Chronic otitis externa.
   a. Chronic fungus infection.
   b. Chronic eczema.
   c. Chronic pyogenic infection.
   d. Chronic ulcerative condition that ranges from syphilis to cancer.

The treatment of these various conditions must be adapted to the individual case. This is very easy to say, but I am ashamed to have to confess that after forty years in practice I am still unable to be dogmatic about it.

The acute mycotic infections will usually yield to any of a number of fungicides, provided the ears are cleansed gently, but thoroughly and regularly. Some physicians simply fill the canals with powder, depending on dryness to retard fungus growth. Cresatin, bismuth violet, gentian violet, and other drugs are efficacious. When there is swelling of the canal, however, it is essential that a wick be kept in the canal to prevent the accumulation of secretion deep in the canal. This applies equally in all inflammations of the external ear accompanied by swelling.

Acute eczema of the ear has given me more trouble than any other form of external otitis. It may spread all over the auricle and adjoining skin and seem to resist any local treatment. Lassar's paste seems to help most of these cases, but I have felt that roentgen therapy has given the best results. Of course, any allergic basis of the trouble should be sought, but I have seldom been able to find the offending food or whatever cause.

I believe that in acute pyogenic infections of the canals usually treatment with wicks saturated with Burow's solution, mercurochrome, bismuth violet, or whatever you like is best until the infection localizes, if it will. I once was prone to incise these infections early, but I have abandoned that practice. In the diffuse type of infection I have found sulfanilamide of invaluable service. Formerly I felt that erysipelas about the ear was a very serious condition, but the use of sulfanilamide has removed that dread. I suppose that penicillin would be effective, but have never had occasion to use it.

The chronic cases really come within the domain of dermatology. Failures are due more to the lack of continued care than anything else. I have seen patients who had had no cerumen in the canals for years and who were subject to recurrent infections return to normal where the patient would use an ichthyol ointment regularly. However, patients will not, as a rule, use anything except when the ears are itching or painful.

The chronic scaly cases are benefited by roentgen therapy and I commend it.

UNRRA ISSUES SECOND ANNIVERSARY REPORT

United Nations Relief and Rehabilitation began operation in August, 1944. The agency has recently issued a report of activities during its two-year lifetime. Among the figures released are those having to do with shipments to countries being assisted by UNRRA, with a small tonnage going to displaced persons operations and other purposes. Through May, the cumulative shipments totaled 11,110,689 tons, of which 101,492 tons were medical supplies. Food came to 5,148,190 tons; industrial rehabilitations supplies to 2,547,288 tons; agricultural rehabilitation supplies to 769,512 tons; clothing, textiles, and footwear to 362,797 tons; and supplies furnished by combined military authorities, 1,181,410 tons.

MALARIA CONTROL IN CHINA

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This paper is to give, briefly, an experience in the control of a disease of great military importance in a large area under circumstances which were peculiar to that theater alone.

China is a large, thickly populated country, the vast majority of whose people are farmers. The terrain is mostly mountainous with fertile valleys between, and a few large rivers. Natural drainage is, as a rule, excellent except for man made obstructions. The people are mostly poor and ignorant but are industrious when working on their own farms. The Chinese coolie labor hired by the Army was of exceedingly poor quality.

Water hazards which promoted the breeding of mosquitoes were many, resulting from the habit of impounding all water possible for domestic purposes. The Chinese seemed to hate to see water escaping down a ditch, and would invariably build a dam across the ditch. There is a rainy season of about three months during the summer. The rainfall is rather heavy at times, and much water is impounded. The largest single water hazard was the rice paddy, and as each paddy was a separate little pond and there were many of them, the control problems were multiplied. An ordinary rice paddy was about half as large as a city lot, and they extended for miles up and down the valleys and sometimes even up the sides of the mountains by means of very beautiful terracing.

Drainage ditches were practically nonexistent. The Chinese could dig pretty looking ditches, but they were the same depth across the flats and up the hills so that water would not run in them.

Another hazard was the cemetery. China, being an old and thickly populated country, has many of them. It used to seem that almost every spot not cultivated in some way was a cemetery. The Chinese practice of burial was to lay the coffin in a slight trench and then erect a large mound of dirt over it, the dirt being dug from the surrounding area. This resulted in many small holes in each cemetery, without the possibility of any drainage.

There was no semblance of any type of sanitation and, as might be expected, the disease rate was high. A Chinese doctor told me that the life expectancy of the Chinese people was about 25 years. American troops began moving into this country in numbers in 1942. As no combat troops, except air force, were brought in, there were only air

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force and service troops in the theater, the service troops being used only to supply the air force, which was doing all the fighting. As a result of this rather peculiar set-up, there were personnel all over China, concentrated around airfields, and there were many airfields.

Transportation was a huge problem. Every single item used by the Army had to be flown in from India, and then redistributed to the various bases, mostly by air. Gasoline was an extremely critical item. As many other supplies were more urgently needed, malaria control material carried usually a No. 3 priority, and was at times rather scarce.

All of these conditions would seem to forecast a huge control problem. However, there were several things that reduced this problem so that the hazard was not so great. Splenic surveys done at the first, indicated that malaria was only mildly endemic in most of the American areas. An altitude of about 6,000 feet with a cool climate minimized mosquito breeding, and the common mosquito found was A. Hyrcanus, which was a poor vector. A. Minimus was found in small quantities at a few of the eastern and northern bases, and most of the malaria occurred in these areas. Malaria discipline, as taught by the Army, ranged from excellent to poor, and most of the small outbreaks that occurred could be traced to poor discipline.

The control problem was eventually worked down to essentially three things: (1) distribution of supplies, mostly pyrethrum aerosol bombs and mosquito repellent; (2) semi-permanent filling and draining projects around the bases, and (3) spraying of breeding places and occasionally a native village. For this work, covering an area nearly as large as the United States, there were one malariologist and two control units, consisting of twenty-two men and three officers, all well-trained in malaria control. These men were spread out, one or two men to a base, to supervise, the actual work being done by coolie labor, the entire program being mapped out by one of the officers and inspected at intervals. Spraying of barracks was done by the occupants with the mosquito bombs, which were one of the best disease prevention inventions of the war. Because of lack of transportation, it was impossible to get a good oil for larvaciding, and either old crank case oil or Chinese tung oil, which resembles kerosene, had to be used. Tung oil was very effective, but too volatile, necessitating frequent spraying. DDT was not available until the very last, after an epidemic at one of the northern bases. This base with 7,000 men had been having 12 to 15 cases per month and suddenly jumped to 200 cases in one month. As a result, it was possible to get a supply of DDT. Two airplanes equipped with homemade sprayers then sprayed the whole valley. This, with a marked improvement in malaria discipline, resulted in stopping the epidemic.

The final outcome of all of these measures was a very low malaria rate, in fact the lowest rate in any of the tropical theaters. Expressed in per cent, the rate was never higher than .5 per cent per month.

Health Department.

MISCELLANEOUS

COMING MEETINGS AND CLINICS

State Medical Association of Texas, Dallas, May 5-8, 1947. Dr. C. C. Cody, Jr., Houston, President; Dr. Holman Taylor, 1404 W. El Paso St., Fort Worth 3, Secretary.

American Medical Association, House of Delegates, Chicago, December 9-11, 1946; Regular General Session, Atlantic City, N. J., June 9-13, 1947. Dr. Harrison H. Shoulders, Nashville, Tenn., President; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secretary.

Southern Medical Association, Miami, Fla., November 4-7, 1946. Dr. M. Y. Dabney, Birmingham, Ala., President; C. P. Loranz, Empire Building, Birmingham, Ala., Secretary-Manager.

Southwest Allergy Forum, Shreveport, La., March 31-April 1, 1947. Dr. W. H. Browning, Shreveport, La., President; Dr. Sim Hulsey, Medical Arts Bldg., Fort Worth, Secretary.

Texas Association of Medical Anesthetists, Dallas, May, 1947. Dr. Claudia Potter, Temple, President; Dr. Russell Bonham, Box 6237, Houston, Secretary.

Texas Association of Obstetricians and Gynecologists, Galveston, November 2, 1946. Dr. Allen McMurrey, Houston, President; Dr. Julius McIver, 714 Medical Arts Building, Dallas, Secretary.

Texas Chapter, American College of Chest Physicians. Dr. R. G. McCorkle, San Antonio, President; Dr. Elliott Mendenhall, 1217 Medical Arts Bldg., Dallas, Secretary.

Texas Club of Internists. Dr. Robert M. Barton, Dallas, President; Dr. Julian C. Barton, 414 Navarro St., San Antonio, Secretary.

Texas Hospital Association, Houston, March 27-29, 1947. Tol Terrell, Harris Memorial Methodist Hospital, Fort Worth, President; Mrs. Ruth Barnhart, 720 College Ave., Dallas, Secretary.

Texas Neuropsychiatric Association, Dallas, May, 1947. Dr. Fred T. Rogers, Dallas, President; Dr. David Wade, 604 Capital National Bank Bldg., Austin, Secretary.

Texas Ophthalmological and Otolaryngological Society, Dallas, December 6-7, 1946. Dr. C. H. Brooks, Waco, Acting President; Dr. E. D. Dumas, 425 Medical Arts Bldg., San Antonio, Secretary.

Texas Orthopedic Society. Dr. E. A. Cayo, San Antonio, President; Dr. Edward Smith, 1215 Walker Ave., Houston, Secretary.

Texas Pediatric Society, Fort Worth, October 4-5, 1946. Dr. Max Woodward, Sherman, President; Dr. John E. Ashby, 3610 Fairmount, Dallas, Secretary.

Texas Public Health Association, Dallas. Dr. L. P. Walter, Austin, President; Mr. Earle W. Sudderth, Dallas County Health Department, Court House, Dallas, Secretary.

Texas Radiological Society, January, 1947. Dr. Herman Klapproth, Sherman, President; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secretary.

Texas Railway and Traumatic Surgical Association. Dr. F. L. Snyder, Fort Worth, President; Dr. Ross Trigg, First National Bank Bldg., Fort Worth, Secretary.

Texas Society for Mental Hygiene. Dr. Jack R. Ewalt, University of Texas Medical Branch, Galveston, President; Mrs. Elizabeth F. Gardner, 1617 Watchhill Road, Austin 21, Executive Secretary.

Texas Society of Gastro-Enterologists and Proctologists, Dallas, May, 1947. Dr. Tom E. Smith, Dallas, President; Dr. D. L. Curb, 704 Dallas Ave., Houston, Secretary.

Texas Society of Pathologists, Houston, January, 1947. Dr. May Owen, Fort Worth, President; Dr. C. T. Ashworth, Southwestern Medical College, Dallas, Secretary.

Texas State Heart Association, Dallas, May, 1947. Dr. Robert M. Barton, Dallas, President; Dr. M. B. Whitten, Medical Arts Bldg., Dallas, Secretary.

Texas State Urological Society, Houston, December 2, 1946. Dr. Joe C. Alexander, Dallas, President; Dr. Michael K. O'Heeron, 901 Medical Arts Bldg., Houston, Secretary.

Texas Surgical Society, Houston, October 7-8, 1946. Dr. G. V. Brindley, Temple, President; Dr. Walter Stuck, 1426 Nix Professional Building, San Antonio, Secretary.

Texas Tuberculosis Association. Dr. J. B. White, Amarillo, President; Miss Pansy Nichols, 700 Brazos, Austin, Executive Secretary.

Third Panhandle, District Medical Society, Lubbock, October 8-9, 1946. Dr. W. A. Carroll, Claude, President; Dr. George Powers, Fisk Bldg., Amarillo, Secretary.

MEDICAL OFFICERS RETURNING TO TEXAS*

(Corrections: Howard P. Gilbert, formerly of Houston, has returned to Denver; Raymond P. Hughes, formerly of El Paso, has joined the U. S. Army and is stationed at Fort Sam Houston.)

NAME	Serv.†	Location	Release Date
Bell County			
17. Barnhart, Joe M., III	A	Temple[1]	
Bexar County			
134. Matthews, J. D. F.	A	San Antonio	
135. Rouse, James W. H.	A	San Antonio	
136. Winter, John W.	A	San Antonio	
Bowie County			
6. Frost, Jack E.	A	De Kalb	
Brazoria County			
4. Laughlin, John M.	A	West Columbia	
Brazos-Robertson Counties			
7. Hopkins, J. J.	A	Bryan[2]	May, 1946
8. Pearson, W. E.	A	Franklin[3]	
Cameron-Willacy Counties			
14. Hawkins, W. W.	A	Brownsville[4]	
15. Spence, Charles H., Jr.	A	Raymondville	
Dallas County			
201. Lumpkin, Walter L., Jr.	A	Dallas	
202. Martin, Thomas A., Jr.	A	Dallas	
203. Stanley, Edward S.	A	Dallas	
Dawson-Lynn-Terry-Gaines-Yoakum Counties			
10. Seale, F. E.	N	Tahoka	May, 1946
Eastland-Callahan Counties			
6. Campbell, Ralph E.	A	Ranger[5]	
Ellis County			
8. McCall, Walter P.	A	Ennis	
9. Wallace, Benjamin C., Jr.	A	Waxahachie	
El Paso County			
55. Floyd, Joe R.	A	El Paso	
56. Marshall, Howard, J. H.	A	El Paso	
57. Multhauf, A. William	A	El Paso	
Galveston County			
56. Heye, Randall G.	A	Galveston	
Grimes County			
4. Madison, John C.	A	Navasota	
Hardeman-Cottle-Foard-Motley Counties			
4. Gilmore, J. T.	A	Crowell[6]	July, 1946
Harris County			
256. Cronin, Thomas D.	A	Houston	Sept., 1946
257. Jackson, James E., Jr.	A	Houston	
Harris County—Continued			
258. Liles, Ralph	N	Houston	
259. Paim, William M.	A	Houston	
260. Wilkinson, Lawrence H.	A	Houston	
261. Williams, Stephen A.	A	Houston	
Henderson County			
3. Schmitt, Herbert S.	A	Malakoff	
Kleberg-Kennedy Counties			
5. Lay, James V. M.	N	Kingsville	
Liberty-Chambers Counties			
5. Fahring, Thomas L.	A	Anahuac	May, 1946
6. Jester, A. W.	N	Crosby[1]	Aug., 1946
Lubbock-Crosby Counties			
22. Clark, V. V.		Lubbock	
McLennan County			
43. Curb, Delos G.	N	Waco	Nov., 1945
44. Fielding, Lewis J.	A	Waco	
45. Nail, Benjamin M., Jr.	A	Crawford	
46. Talley, John E.	A	Waco[2]	
47. Wells, William H.	A	Waco	
Medina-Uvalde-Maverick-Val Verde-Edwards-Real-Kinney-Terrell-Zavala Counties			
8. Norman, Earle T.	A	Uvalde	
Nacogdoches County			
4. Taylor, James G., Jr.	A	Nacogdoches[3]	May, 1946
Nueces County			
35. Sloan, John J.	A	Corpus Christi	
Panola County			
1. Daniels, DuBose	A	Carthage[4]	
Potter County			
30. Wegener, Karl F. E.	A	Amarillo	May, 1946
Reeves-Ward-Winkler-Loving-Culberson-Hudspeth Counties			
6. Crumpler, Hulen P.	A	Pecos	
Rusk County			
10. Heiligman, Emmett M.	N	Overton	
11. McNabb, Joseph F.	A	Price	
San Patricio-Aransas-Refugio Counties			
10. Tunnell John W.	A	Gregory	
Shelby-San Augustine-Sabine Counties			
8. Warren, William S.	A	Center	
Smith County			
15. Bailes, Porter M., Jr.	A	Tyler	
Taylor-Jones Counties			
21. Selmon, Tony	N	Shamford	July, 1946
Tom Green-Coke-Crockett-Concho-Irion-Sterling-Sutton-Schleicher Counties			
21. Sessums, John V.	A	San Angelo	
Travis County			
52. Moore, Roscoe O.	A	Austin	
53. Pollard, Claude, Jr.	A	Austin	
54. Watt, Terrence N.	A	Austin	
Victoria-Calhoun-Goliad Counties			
6. Melcher, Truman O.	A	Port Lavaca	May, 1946
7. Ogden, U. B.	A	Victoria	
Wharton-Jackson-Matagorda-Fort Bend Counties			
16. Hollomon, J. J.	A	Edna	
Williamson County			
6. Lehmberg, S. W.	A	Taylor[5]	Sept., 1946

*EDITOR'S NOTE: This list is the twelfth of a series in which it is hoped to name all those physicians who have been in the Armed Forces during the war recently passed and have now returned to Texas to resume civilian practice. The information in this list has been assembled from a variety of sources. While an attempt has been made to secure as complete and as accurate data as possible, we are aware that omissions and errors have been made. Not only for publication in the JOURNAL but also for the permanent records in the central office of the State Medical Association, we invite and urge correction of and addition to the material here submitted. Note that physicians from each county area are numbered consecutively following those listed in the September JOURNAL; the last number in each section therefore indicates the total physicians returned to that county area. The complete total for Texas named to date (September 20), including the accompanying list, is 1,705.

†A=Army; N=Navy; U=U. S. Public Health Service.
[1]Formerly of Beeville.
[2]Formerly of Baytown.
[3]Formerly of Dallas.
[4]Formerly of Waco.
[5]Formerly of Fort Worth.
[6]Formerly of McKinney.

[1]Formerly of Houston.
[2]Formerly of Hamilton.
[3]Formerly of Dallas.
[4]Formerly of Waskom.
[5]Formerly of Georgetown.

Fourth District Medical Society, Brady, November, 1946. Dr. H. L. Locker, Brownwood, President; Dr. Glenn H. Ricks, Brady, Secretary.

Seventh, Austin, District Society. Dr. Robert B. Morrison, Austin, President; Dr. M. I. Brown, Capital National Bank Bldg., Austin, Secretary.

Eighth, Ninth and Tenth Districts Medical Society, Orange, April, 1947. Dr. Walter F. Hasskarl, Brenham, President; Dr. George W. Waldron, Medical Arts Bldg., Houston, Secretary.

Eleventh District Society, Palestine, October 31, 1946. Dr. L. L. Travis, Jacksonville, President; Dr. C. B. Young, 929 S. Confederate, Tyler, Secretary.

Twelfth, Central Texas District Society, Temple, January 14, 1947. Dr. Thomas G. Glass, Marlin, President; Dr. H. F. Connally, Jr., Amicable Bldg., Waco. Secretary.

Thirteenth, Northwest District Society, Graham, October 24, 1946. Dr. A. L. Roberts, Fort Worth, President; Dr. Joe R. Wise, 1212 W. Lancaster, Fort Worth, Secretary.

Fourteenth District Society, Dallas, December 10, 1946. Dr. C. B. Thayer, Gainesville, President; Dr. V. L. Tuck, Sherman, Secretary.

Fifteenth, Northeast Texas, District Society, Marshall. October 8, 1946. Dr. Frank Littlejohn, Marshall, President; Dr. Henry H. Neihuss, Greggton, Secretary.

CLINICS

Dallas Southern Clinical Conference, Dallas, March 17-20, 1947. Miss Thelma J. Webb, 1133 Medical Arts Bldg., Dallas 1, Executive Secretary

New Orleans Graduate Medical Assembly. New Orleans, February 24-27, 1947. Dr. Max M. Green, Room 105, 1430 Tulane Ave., New Orleans 13, Secretary.

Oklahoma City Clinical Society, Oklahoma City, October 28-31, 1946. Executive Secretary, 512 Medical Arts Bldg., Oklahoma City.

Post Graduate Medical Assembly of South Texas, Houston, December 3-5, 1946. Secretary, 229 Medical Arts Building, Houston.

MINUTES OF EXECUTIVE COUNCIL of STATE MEDICAL ASSOCIATION

The Executive Council of the State Medical Association of Texas was called to order at 9:30 a. m., Sunday, September 29, 1946, in Centennial Room 2 of the Hotel Texas, Fort Worth, by President Dr. C. C. Cody.

Roll call revealed the following persons present:

Executive Council—*Officers:* Drs. C. C. Cody, Houston, President; B. E. Pickett, Carrizo Springs, President-Elect; C. P. Yeager, Corpus Christi, Vice-President; Holman Taylor, Fort Worth, Secretary; *Board of Trustees:* Drs. T. C. Terrell, Fort Worth, chairman; E. A. Rowley, Amarillo, E. W. Bertner, Houston; *Board of Councilors:* Drs. Ralph H. Homan, El Paso, District 1; Harvey H. Latson, Amarillo, District 3; O. N. Mayo, Brownwood, District 4; C. E. Scull, San Antonio, District 5; W. E. Whigham, McAllen, District 6; R. T. Wilson, Austin, District 7; F. J. L. Blasingame, Wharton, District 8; Ghent Graves, Houston, District 9; J. M. Travis, Jacksonville, District 11; G. V. Brindley, Temple, District 12; R. G. Baker, Fort Worth, District 13; C. C. Nash, Dallas, District 14; *Legislative Committee:* Drs. J. H. Burleson, San Antonio, chairman; L. H. Reeves, Fort Worth; J. Allen Kyle, Houston; Z. T. Scott, Austin.

Visitors by invitation—*Public Relations Committee:* Drs. Merton M. Minter, San Antonio, chairman; R. A. Miller, San Antonio; Allen T. Stewart, Lubbock; George Schenewerk, Dallas; J. E. Hogan, Big Spring; R. B. Anderson, Fort Worth, secretary (ex officio); *Council on Medical Economics:* Drs. H. E. Griffin, Graham, chairman; Tom B. Bond, Fort Worth; *Woman's Auxiliary:* Mrs. George Turner, El Paso, President; Mrs. A. B. Pumphrey, Fort Worth, Legislative Chairman; *others:* Mr. Jeff Reese, Fort Worth, legislative counsel; Mr. Philip E. Fox, Dallas, public relations counsel; Mr. Michael B. Crowson, assistant public relations counsel; Judge Ralph Yarbrough, Austin, special legal counsel; Mr. J. Louis Neff, Houston, executive director, Texas Division, American Cancer Society; Mr. Philip Overton, Austin, Texas Hospital Association, legal counsel; Dr. Helen T. Konjias, Austin, director of Texas child health survey program of American Academy of Pediatrics; Dr. George W. Cox, Austin, state health officer; Dr. J. B. Copeland, San Antonio; Dr. Stuart A. Wallace, Houston, Baylor University College of Medicine; Dr. L. B. Jackson, San Antonio, chairman, Council on Medical Economics; Dr. H. F. Connally, Waco; Dr. and Mrs. S. E. Thompson, Kerrville.

President Cody reported that Dr. N. D. Buie, Marlin, member of the Legislative Committee, had wired his regret at being unable to attend because of a recent illness from which he was convalescing.

Minutes of the previous meeting were not read, since business transacted at that meeting had already been considered by the House of Delegates of the Association and the minutes themselves had been printed in the JOURNAL (April, 1946, pp. 670-674).

Upon the request of President Cody, Dr. Griffin, chairman of the Council on Medical Economics, presented the report of that Council. Dr. Griffin said that the Council is constantly trying to protect the physicians of the state, and also the people of the state, and that the objectives of the Council are the same as in recent years. He pointed out that it is not the present policy of the Council to endorse any specific company or insurance plan designed to provide group hospital and medical service, despite resolutions adopted at the last meeting of the Executive Council and ratified by the House of Delegates at Galveston. The primary reason for failure to endorse specific plans is the belief of the Council that the present schedule of fees allowed by insurance plans is so low that until the volume of participants is large, doctors cannot be paid satisfactory fees, and that unless fees are placed at a reasonably high level while times are good, it will be impossible to raise them to cover the situation when bad times arrive. Efforts to persuade insurance companies and so-called nonprofit groups to raise fees to a satisfactory level have been unsuccessful. In recent weeks, Dr. Griffin continued, a canvas has been made of county medical societies to discover what fees are charged in general practice in the various areas of the state. The average charges reported will probably serve as a guide in the future. The canvas was made primarily because of the problem of returning veterans, who must be cared for. If it is possible to establish average fees for medical service to veterans which will be acceptable to physicians and to the Veterans Administration, such a scale of fees will prove very helpful. Dr. Griffin expressed the hope that in the near future there will be for the guidance of the Council, an agency in the central office of the Association to study and evaluate nonprofit and all insurance plans for prepaid medical service. He read three additional points which the Council on Medical Economics has added to its standards for medical service plans, making a total of nine points. The new standards follow:

6. In group insurance, the indemnity shall be payable for the service regardless of whether rendered in the patient's home, doctor's office, or hospital.

7. In group insurance, the schedule of surgical indemnities shall assure the policy holder the same proportionate protection for the various services rendered.

8. In group insurance, the optimum indemnity percentage of the average fee for service rendered may be regarded as 80 per cent of the usual charge.

Dr. Terrell wanted to know why 20 per cent should be allowed off fees.

Dr. Griffin replied that the question had been argued often, but that it was traditional to give discounts to patients unable to pay full, regular fees, although physicians should receive 100 per cent payment just as "union members" do.

Dr. Cody added that a discount was not actually proposed; that insurance companies would merely indemnify the patient for approximately 80 per cent of the average medical fee, but that the indemnity would not set the fee.

Dr. Terrell declared that fees would seek a level based on the lower indemnity figure.

Dr. Cody agreed that if the indemnity were the same as the fee, the general level of fees for a community would be the same, regardless of whether the patient were under a group plan or not, but that the Council is attempting to separate the fee and the indemnity.

Dr. Terrell inquired whether the patient would pay the additional 20 per cent.

Dr. Cody said that the insurance company indemnifies the patient for 80 per cent of the average fee, but that the relationship between patient and doctor remains personal, and that the patient would have to make up any difference necessary to cover the fee.

Dr. Anderson was requested by President Cody to discuss the hospital and medical service survey which is being made. Dr. Anderson pointed out that when passage of the Hill-Burton Hospital Construction Bill by Congress seemed assured, decision was made by the State Medical Association to make its own survey of hospital and medical service needs in preparation for carrying out the provisions of the bill. About February, 1946, county medical societies were requested to appoint committees for this purpose, and blank forms were sent out requesting data from these committees. To date, 73 societies have re-

sponded, with 51 making no reports. Committees, however, have been appointed in 68 county societies leaving 56 without committees. Dr. Anderson reminded that the State Health Department, the official agency in Texas, as designated by the Governor, has employed a director to make an official survey of the state, and that the State Medical Association is represented on the advisory council for that survey; but that the State Medical Association will have no recourse but to accept the Health Department survey and recommendations unless it makes its own survey through county medical societies, and that the county organizations will have to respond to make the State Medical Association survey a success. He read a list of the county societies which have failed to respond to the request for information, and urged that Councilors attempt to secure replies from the societies that had not responded. He displayed two charts showing how the results of the questionnaires have been tabulated to make the information readily accessible, and pointed out that such information will be invaluable to the Council on Medical Education and Hospitals, Council on Medical Economics, and other councils and committees working in the general field of hospital and medical service.

Dr. Cody urged the necessity of furnishing the central office and statewide councils and committees with facts and the necessary ammunition to fight the battles of the medical profession, and appealed for prompt replies to requests for data. Dr. Taylor reemphasized Dr. Cody's plea.

Dr. Brindley suggested that since some of the Councilors were not present, and others might have had difficulty in recording the names of delinquent counties in their districts, a letter from the central office indicating the societies from which data should be secured be sent to each Councilor, with a request for his assistance in the problem.

Dr. Griffin moved the approval of the report of the Council on Medical Economics. Following second by Dr. Travis, the motion passed.

President Cody called for a report from the Legislative Committee. Dr. Burleson declared that the objective of the Legislative Committee for the year is to secure passage by the Legislature of a Basic Science bill and a revised Medical Practice Act bill. The Legislative Committee believes that the results of the recent election make accomplishment of this objective a definite possibility, but that a fight will be necessary and success cannot be attained with dissension in the ranks of the Association. The committee believes that it has received a mandate from the House of Delegates to secure passage of the two bills mentioned, and that the committee is not attempting to originate legislation. Dr. Burleson indicated that while the Legislative Committee has looked with favor on and will give assistance to passage of legislation proposed by the Texas Tuberculosis Association and of the Coroner's bill, primary attention will be focussed on the two bills which the State Medical Association itself plans to introduce. He said that these bills, first written several years ago, have been revised somewhat, and he introduced Judge Ralph Yarbrough, Austin, who was employed to assist in their revision, to explain the present drafts.

Judge Yarbrough recalled that the Basic Science bill and the new Medical Practice Act bill, had been published in the March, 1943, JOURNAL. He said that the Legislative Committee had considered the bills at its June, 1946, meeting, and that some additional revision had been made since then upon the advice of various persons to whom copies of the bill had been submitted. The Legislative and Public Relations Committees considered the bills again September 28.

The main changes in the Basic Science bill, Judge Yarbrough described as having to do with strengthened enforcement. He said that the membership of the Basic Science Board of Examiners had been tightened, reciprocity limited, grievance appeals made possible outside of Travis County, and enforcement measures noticeably strengthened. He pointed out that the penalty for bribery and other fraud in connection with securing a Basic Science certificate had been changed from the misdemeanor to the felony level because similar fraud in other public fields in the state were on the felony level.

Dr. Scott wanted to know whether a board of six members would be legal or whether an uneven number would not be necessary.

Judge Yarbrough said that the number of members has been left at six as in the originally drawn bill, and that if the Legislature passes the bill the six-man board will be legal, for it violates no provision of the Constitution. There will be no need to make the number uneven unless the State Medical Association is opposed to even membered boards.

The proposed Medical Practice Act bill was then considered by Judge Yarbrough, who explained that it is anticipated passage of this bill will not be pressed until the Basic Science bill has been passed because the changes in the Medical Practice Act are dependent for their effectiveness on the Basic Science bill. The new bill does not provide for licensing of osteopaths or chiropractors, who will presumably be licensed by their own boards after certification by the Basic Science Board. The bill likewise eliminates from the licensing examination the subjects which under the Basic Science bill are given in the basic science examination, and repeals the annual registration fee. Most revisions in the bill are designed to strengthen and tighten it.

Dr. Brindley inquired whether interns and residents are excepted under the bill. Judge Yarbrough said that there are no changes from the present act with regard to interns and residents.

Dr. Wilson wanted to know the number of members who will be on the board of examiners. Judge Yarbrough replied that there will be six.

Dr. Burleson moved that both the Basic Science bill and the Medical Practice Act bill be approved as submitted. Dr. Reeves seconded the motion.

Dr. Terrell offered as an amendment that on page 2, section 3, lines 55, 56, and 59, of the Medical Practice Act bill, the word "diagnose" or "diagnosis" be inserted in addition to the word "treat" or "treatment." Dr. Nash seconded the amendment.

Dr. Minter expressed the view that inclusion of the word "diagnose" will not stop a laboratory from giving reports on tests, whether or not a physician directs the laboratory.

Dr. Terrell insisted that he was not asking for elimination but for a trial.

Dr. Nash pointed out that cults will make attacks on the bill and will hunt for every loophole, and that inclusion of the word "diagnose" will be helpful in combatting the cults.

The amendment was unanimously approved.

Dr. Taylor asked for clarification as to whether approval of the amendment meant that inclusion of the word "diagnose" was mandatory on the Legislative Committee or merely advice.

Dr. Cody replied that unless there are objections, he will rule that it is a mandate. The Council voiced no objection.

Dr. Brindley suggested that the Medical Practice Act bill should be definite with regard to interns and residents, and should list them along with nurses, on page 5, section 12, line 61, as being excluded from provisions of the bill.

Dr. Rowley declared that whether a physician is an intern or a resident or not, he still practices medicine.

Dr. Brindley pointed out that many interns or residents from out of the state come to Texas for only one or two years, and might be handicapped if they were forced to secure Texas licenses.

Dr. Taylor said his son had had to be licensed in Michigan to serve a residency there.

Dr. Bertner feared that if interns and residents are excluded from the bill, there will soon be no control over who employs interns and residents, and the result will be trouble.

Dr. Rowley agreed that it will be dangerous to leave the field wide open. He said Dr. Connally, a member of the present Board of Medical Examiners, believes that most hospitals request licensing of their interns and residents.

Dr. Taylor wanted to know whether the courts have not ruled that an intern or resident in a hospital who accepts patients is not actually practicing medicine and subject to licensing.

Dr. Connally replied that there may not have been a court ruling in the matter, but that general practice is in accordance with Dr. Taylor's understanding. The hospital is responsible for its interns and residents, but most hospitals will not accept such responsibility unless the intern or resident has a license. Licensing is a protection to the hospital as well as to the public.

Judge Yarbrough said that the 1943 Medical Practice Act bill, now under consideration, with a few revisions, does not change existing law regarding interns and residents. In the past the medical profession has largely controlled its interns and residents and little court action has been taken. In court a decision would depend on what the intern was doing in an individual case.

Dr. Bertner believed the situation already taken care of, as medical schools urge their graduates to obtain licenses promptly.

Dr. Brindley argued that some graduates cannot take an examination for a license until three or four months after their graduation, which prevents them from beginning an internship until that time if a license were required.

Dr. Bertner pointed out that as the new bill makes no change in the status of interns and residents, the present practice of the hospitals can be continued.

Dr. Graves reported that Massachusetts issues a restricted license for interns.

Dr. Brindley moved that interns who are graduates of class A medical schools be permitted to serve a twelve month internship in a hospital without a license, provided the hospital assumes responsibility for the intern's acts, this provision to be inserted on page 5, line 61 of the Medical Practice Acts bill.

Dr. Bertner declared that the kind of hospital eligible to take interns will have to be named.

The motion died without a second.

Dr. Brindley then moved that the attorney and the Legislative Committee study the Medical Practice Act bill with regard to the rights of interns and residents, and act on its studies. Dr. Travis seconded the motion.

Dr. Burleson voiced opposition to the motion because it places the responsibility on the Legislative Committee to make a decision which he considered the Executive Council should determine.

Dr. Jackson suggested that since the State Medical Association provides for an intern membership, at $4 per year, $1 of which goes toward medical defense, the Association assumes that interns are licensed.

Dr. Brindley declared that the attorney had already said he does not know the rights of interns and that the motion was intended to force additional study where information is not complete.

Dr. Moore expressed the opinion that the simplest thing to do would be to license all interns and residents even though an occasional inconvenience to a hospital or an intern or resident would occur.

The motion failed to pass.

Approval of the Basic Science bill and Medical Practice Act bill, with the amendment adding the word "diagnose" to the definition of the practice of medicine, was unanimous.

Dr. Burleson moved that the Council endorse the legislation of the Tuberculosis Association and the Coroner's bill. Dr. Reeves seconded the motion, which passed unanimously.

President Cody called on Dr. Pickett to report for a subcommittee of the Legislative Committee, appointed September 28 to consider the Taft-Smith-Ball National Health bill. The subcommittee was composed of Dr. Pickett, chairman, and Drs. Scott and Taylor. Dr. Pickett indicated that the report was being made at the request of the Washington and Chiago offices of the American Medical Association Bureau of Legal Medicine and Legislation, which wishes to have the opinion of physicians throughout the nation on the bill. The report declared that the subcommittee considered the bill the most satisfactory and workable bill from the standpoint of the medical profession and the public to originate in Washington, and exception was taken only to the provision for a National Health Council as advisors to the Surgeon General of the U. S. Public Health Service, it being the opinion of the committee that a majority of all members of such advisory committees should be graduates in medicine. Dr. Pickett moved adoption of the report. Dr. Scott seconded the motion and it was unanimously passed.

President Cody recognized the presence of Mrs. George Turner, El Paso, President of the Woman's Auxiliary; Mrs. A. B. Pumphrey, Fort Worth, chairman of the Legislative Committee for the Auxiliary; and Mrs. S. E. Thompson, Kerrville, past president of the Auxiliary; and expressed regret that Mrs. J. B. Foster, Houston, chairman of the Auxiliary's Public Relations Committee, was unable to be present. Mrs. Turner and Mrs. Pumphrey expressed their appreciation of the invitation to attend the Executive Council meeting, and expressed great interest in the activities of the Association.

Dr. Bertner, upon the request of President Cody for direction in prosecuting the passage of the Basic Science and Medical Practice Act bills, moved that the bills be reprinted, with the revisions which had been made, and distributed to Councilors, county medical societies, and others, to facilitate passage of the bills. The motion was seconded by Dr. Yeager.

President Cody suggested that members of the Legislature should be interviewed personally at frequent intervals between now and January 1, to maintain their interest in passage of the bills. He insisted that it would not be wise to assume as true, rumors that a member of the Legislature is fighting the State Medical Association or is for it; that the facts must be obtained first hand.

Dr. Bertner's motion passed unanimously.

President Cody called on Dr. Minter for a report of the Public Relations Committee. Dr. Minter said that a letter on the shortage of nurses had been circulated recently by the committee, and replies from various physicians had indicated the necessity for three modes of attack: (1) certification of more schools of nursing in Texas, particularly in smaller hospitals; (2) cessation of exploitation of student nurses by hospitals, coupled with institution of salaries for student nurses; (3) increased encouragement by physicians of girls to go into the nursing profession.

Dr. Minter called the attention of the council to recent suits regarding rebates on eyeglasses, a practice which has been condoned for many years but which is considered unethical. He read a resolution proposed by the Public Relations Committee condemning the practice of accepting rebates on prescriptions and appliances as in violation of the Principles of Medical Ethics, and requesting that boards

of censors of county medical societies see that such practices are stopped and suitable disciplinary action taken where necessary.

Dr. Minter then moved that, upon recommendation of the Public Relations Committee, a committee be appointed from the Public Relations Committee to serve as a liaison with the Texas Hospital Association and Nurses Association, to study, investigate, and act on the nursing shortage problem. Drs. Reeves and Travis seconded the motion, which was unanimously approved.

Dr. Minter moved adoption of the resolution regarding rebates, and Dr. Mayo seconded the motion.

Dr. Burleson urged that the Public Relations Committee have a committee similar to the one for the nursing problem, to consider the problem of rebates. for in his opinion the Public Relations Committee is not fully aware of the situation. He said the resolution was out of line, uncalled for, and would stigmatize a great number of reputable physicians; that the discount or rebate system mentioned had been in operation for all the forty years of his practice, and stopping it would not make glasses cost less.

Dr. Taylor rose to a point of order, and read from Section 1, Article 5 of the Constitution, in which provision is made for referral of matters of medical ethics to the Board of Councilors.

Dr. Minter said that Dr. Burleson had made two points: (1) he had been concerned with the problem for forty years and had been able to do nothing about it, and (2) a number of physicians would be stigmatized. He pointed out that the medical profession could not go to business firms and tell them what to charge, and attack the problem from that angle. He read from an editorial in the August 3, 1946, *Journal of the American Medical Association* specifically calling attention to the practice of rebates as contrary to the Principles of Medical Ethics, and declared that if a practice is being carried on by the physicians of Texas which is regarded as unethical by the American Medical Association and the State Medical Association, it might be well to start house cleaning at home.

President Cody said that Chapter 3, Article 1, Section 5, of the Principles of Medical Ethics provides that matters of the sort be called to the attention of the Board of Councilors. His decision was to refer the problem of rebates and the resolution thereon to the Board of Councilors for consideration.

Dr. Minter called on Dr. Hogan to present the matter of adjudication boards.

Dr. Hogan reported that Harris County Medical Society several years ago set up an adjudication board to hear complaints and assist in working out suitable fees in industrial practice. The board has recently been directed to hear general complaints by patients, thus serving as a sort of public relations board. The Public Relations Committee considered that a similar plan might be instituted to advantage in other county medical societies.

President Cody asked for a motion that county medical societies be invited to set up adjudication committees to discourage exploitation and chiseling by physicians, and to explain to patients that in many instances they receive more for their money than they realize.

Dr. Graves moved that the Executive Council recommend the setting up of adjudication committees by each county medical society. Dr. Minter seconded the motion, which passed unanimously.

Dr. Minter requested Dr. Schenewerk to report on county medical society preceptorships. Dr. Schenewerk outlined a proposed course of six lectures on medical history and ethics, legal medicine, building up a practice, relationship to Veterans Administration, and so forth, which the Public Relations Committee considered valuable for prospective county medical society members, especially transfers from other states and young physicians. He pointed out that the Los Angeles County Medical Association and other societies, had found the plan of requiring prospective members to attend lectures and pass an examination on similar courses of great value in orienting the new members. He moved that the Executive Council approve the voluntary organization of councils on medical preceptorships in the larger county medical societies, and in such smaller societies as wish them. Dr. Reeves seconded the motion.

Dr. Graves wanted to know whether the course would be compulsory prior to acceptance for membership if the county medical society so rules.

President Cody said it will be left to the county medical society to decide whether the course will be compulsory, voluntary, or not used at all.

Dr. Nash feared that requirements for membership are already somewhat involved, and that a six-lecture course will add so much rigmarole prospective members will be discouraged.

Dr. Taylor rose to a point of order. In addition to the difficulty involved in getting smaller societies to act on the matter, he wished to point out that the Judicial Council of the American Medical Association is leery about allowing county medical societies to inhibit membership. The matter, however, according to Chapter 11 of the By-Laws, is strictly up to the Board of Councilors to decide.

Dr. Graves recommended that the motion be amended to make the course voluntary for prospective members rather than compulsory.

President Cody believed that the current enormous number of transfers from other states would make wise a formal orientation course to give unity to the membership.

Dr. Schenewerk declared that the plan was proposed to help new members rather than to impose a hardship on them.

President Cody added that another reason for such a course would be the opportunity given for older members, particularly in large societies where there are many new members coming in, to know more about applicants.

Dr. Taylor raised again the question of legality of making such a course compulsory and a predicate for membership.

President Cody reminded that Dr. Graves' amendment would make the course voluntary.

Dr. Nash wanted to know of what value the course would be if it were voluntary, since very few would probably take advantage of the lectures. The Boards of Censors should consider applicants and know whether they are worthy of membership.

The vote was 10 for and 8 against approval of voluntary preceptorship courses, and the motion was declared adopted.

Dr. Minter introduced Dr. Stewart, who reported on the status of coöperative hospitals. He reviewed the growth of coöperative hospitals in Texas following passage of a bill in the Legislature making such hospitals possible, and pointed to some of the advantages and disadvantages of the method of providing hospital care. In conclusion, he recommended (1) conferences with rural farm groups indicating the willingness of the Association to coöperate in improving rural health; (2) approval of community hospitals which are maintained according to standards of medical ethics; (3) insistence that community hospitals are on dangerous ground because in some instances they may in effect be a corporation practicing medicine, which is illegal; (4) direction of the attention of rural communities to the availability of prepayment plans for hospital and medical service at lower cost than coöperative hospital plans offer. He moved acceptance of the report, and the motion was seconded by Dr. Terrell. It was unanimously adopted.

Dr. Minter concluded the various Public Relations Committee reports by saying that his committee had

met with the Legislative Committee September 28, and will continue to work closely with that committee.

Dr. Taylor was requested by President Cody to introduce the matter of a pediatric survey now being conducted in Texas. Dr. Taylor recalled that the survey, under the auspices of the American Academy of Pediatrics, had been considered by the House of Delegates in Galveston and that, upon the recommendation of the reference committee to which the problem had been referred, the House of Delegates had left the matter open pending action by the Texas Pediatric Society (TEXAS STATE JOURNAL OF MEDICINE, June, 1946, pp. 122, 130). He quoted from a letter by Dr. John E. Ashby, Dallas, secretary of the Texas Pediatric Society, certifying that the Pediatric Society has approved the survey, and from another letter by Dr. Thomas J. McElhenney, Austin, and Dr. Bruce A. Knickerbocker, Dallas, state chairmen of the child health survey, requesting the Executive Council of the State Medical Association to approve the survey. He then presented Dr. Helen T. Konjias, Austin, who is directing the survey in Texas.

Dr. Konjias read excerpts of an editorial from the May, 1946, *Journal of the American Medical Association*, which gave wholehearted approval to the American Academy of Pediatrics child health survey and urged coöperation of physicians throughout the country in the survey.

Dr. Taylor moved that the Executive Council approve the study of child health services being made at the present time by the Texas Pediatric Society in coöperation with the American Academy of Pediatrics, pursuant to action of the House of Delegates at Galveston pertaining to the matter, the Texas Pediatric Society having approved the study. Dr. Travis seconded the motion, which carried unanimously.

Dr. Konjias said that the American Academy of Pediatrics had left up to the state medical societies decision as to whether osteopaths should be included in the child health survey, particularly since osteopaths, in some states, at least, allegedly have a large percentage of the care of infants and children. She requested that the Executive Council instruct her as to whether the osteopaths should be included in the Texas survey.

President Cody opened the question for a motion to include the osteopaths, but none was made.

President Cody asked Dr. Taylor to introduce the matter of mental health and hygiene. Dr. Taylor reported that the American Medical Association had requested the State Medical Association to concern itself with mental health and hygiene and that the Texas Society for Mental Hygiene and the Texas Neuropsychiatric Association had approved the idea. He moved that the matter be referred to the Committee on Mental Health of the State Medical Association, with a view to coöperating with the mental health program. Dr. Brindley seconded the motion, which carried unanimously.

Dr. Nash moved that the Council recess at 1 p. m. for lunch to reconvene at 2 p. m. The motion passed.

Before recessing, President Cody formally presented Dr. Latson as the new Councilor for District 3.

The Executive Council reconvened following lunch, and Dr. Brindley, chairman of a subcommittee of the Board of Councilors, was called on by President Cody to report regarding possible changes in Councilor districts. Dr. Brindley stated that the majority of districts do not want to be changed, though most of them would be willing to be enlarged. He urged that the Council either agree that no changes be made in the districts or that additional studies be made before action is taken. He then outlined the possible changes in districting which the subcommittee had considered.

Dr. Rowley insisted that the Third District is happy as it is now constituted, and while it would be pleased to annex societies, it does not want to lose any. Dr. Stewart agreed that the Lubbock area would like to stay with Amarillo.

Dr. Travis indicated that the Eleventh District would be delighted to have Rusk County moved back into that district.

Dr. Reeves assured the Council that the Thirteenth District is satisfied, but he believed the good of the Association as a whole should be considered. He moved that the subcommittee continue its investigation of the redistricting problem and report through the Board of Councilors to the House of Delegates at the next annual session if its studies were complete by that time. Dr. Burleson seconded the motion, which carried unanimously.

Dr. Anderson suggested that the subcommittee also consider combining some of the smaller county societies within Councilor districts in order to make stronger county organizations.

President Cody gave his view that the Board of Councilors holds the Association together and that strong Councilor districts are essential to a strong Association. He noted that under a new rule Councilors are to be nominated by districts, and if the districts fail to nominate there is no method specified whereby to secure new Councilors.

Dr. Bertner was requested by President Cody to discuss cancer activities in the state. Dr. Bertner, in turn, introduced Mr. J. Louis Neff, executive director of the Texas Division, American Cancer Society. Mr. Neff reminded that the House of Delegates in Galveston had endorsed the program of the American Cancer Society, that the American Cancer Society carried on all of its medical activities under the direct supervision and approval of organized medicine; and that the sole objective of the Cancer Society is to secure early diagnosis and adequate treatment of cancer. To carry out its objective, it is necessary for the patient to report promptly to his family physician any symptoms which might indicate cancer, and for the physician to obtain suitable examination and diagnosis. He said that in other states pamphlets aimed toward helping achieve those ends have been distributed over the signature of the State Medical Association but at the expense of the American Cancer Society. He requested approval by the Executive Council of such a plan for Texas, and specific approval of the several pamphlets of a medical nature, which he displayed.

Dr. Bertner said he would vouch for the acceptability of the pamphlets, and moved that Mr. Neff's request be approved. Upon second by Dr. Whigham, the motion carried unanimously.

President Cody announced the invitation of the American Medical Association to the State Medical Association, to participate in the one hundredth anniversary celebration of the national organization next year. He assumed that the State Medical Association would gladly take part in the celebration.

President Cody brought up the question of whether Association committees which had once been useful but have now become inactive, should be continued from year to year, naming particularly the committee dealing with fractures, malaria, pneumonia, and liaison with the Lone Star State Medical, Dental, and Pharmaceutical Association.

Dr. Travis moved the discontinuance of such committees until such time as they might again appear to be necessary. Dr. Burleson seconded the motion, which passed unanimously.

President Cody called for any new business.

Dr. Stuart Wallace, Baylor University College of Medicine, Houston, expressed his thanks for the opportunity to attend the meeting.

Dr. Wilson moved that the Council adjourn, Dr. Brindley seconded the motion, it carried, and adjournment was had at 2:50 p. m.

PEDIATRIC CONFERENCE PROGRAM ANNOUNCED

The tentative program for the University of Texas Pediatric Conference, to be held October 28-November 2 in Galveston with the coöperation of the Division of Maternal and Child Health of the State Health Department, has been released by Dr. Arild E. Hansen, chairman of the University Department of Pediatrics. Application to attend the conference, the first of this year's special postgraduate courses to be offered by the University of Texas School of Medicine, should be sent to Dr. Hansen.

Guest speakers for the conference include the following:

Dr. Myron Wegman, Louisiana State University School of Medicine, New Orleans.

Dr. Wilburt C. Davison, Duke University School of Medicine, Durham, N. C.

Dr. Franklin Henry Top, Wayne University College of Medicine and Herman Kiefer Hospital for Contagious Diseases, Detroit.

Dr. Douglas N. Buchanan, University of Chicago School of Medicine, Chicago.

Dr. Julian D. Boyd, State University of Iowa College of Medicine, Iowa City.

Dr. Daniel C. Darrow, Yale University School of Medicine, New Haven, Conn.

Dr. Edward L. Pratt, Yale University School of Medicine, New Haven, Conn.

Dr. James Flett, Jr., Yale University School of Medicine, New Haven, Conn.

Dr. Russell K. Smith, University of Texas School of Dentistry, Houston.

Members of the University of Texas Medical Branch staff who will participate include Drs. Hansen, J. K. Lamar, Alice Gamble, Boyd Reading, J. L. Treadway, Jr., Robert A. Gardner, Nuel C. Windrow, Jr., Francis A. Garbade, William C. Levin, Paul Brindley, Erle E. Wilkinson, Randolph L. Schaffer, Morris Pollard, Groom S. Shepard, G. W. N. Eggers, J. H. Waterman, A. O. Singleton, Robert E. Leaton, Harry H. Womack, and MacDonald Fulton, Ph. D., and Hilda Walker, R. N.

The tentative schedule for the conference, sessions of which will be at Randall Hall on the University campus unless otherwise noted, follows:

October 28

(8:30) Registration.
(9:00-12:00) Problem of Diarrhea in Infants—Dr. Hansen, chairman.
(9:05) General Scope of Problem—Dr. Wegman.
(9:35) Specific Treatment of Dehydration—Dr. Darrow.
(10:15) Bacteriological Aspects of Infantile Diarrhea.—Dr. Fulton.
(10:30) Treatment of the Bacteriologic Phase of Diarrhea—Dr. Gamble.
(10:45) Intermission.
(11:00) Presentation of Cases—Dr. Treadway.
Technical Considerations in Treatment—Dr. Flett.
(2:00-3:45) Endocrine Disorders in Children—Dr. Reading, chairman.
(2:00) Orientation of Endocrine Field—Dr. Hansen.
(3:00) Hormone Assays As a Means of Diagnosis—Dr. Lamar.
(3:20) Biochemical Determinations to Aid in Diagnosis—Dr. Pratt.
(3:45) Intermission.
(4:00) Significance of Physical Measurements in Pediatric Diagnoses—Dr. Boyd.
(8:00) William Buchanan Lecture: Development in Treatment of Diarrhea—Dr. Barrow (Room 102, Laboratory Building).

October 29

(9:00-12:00) Dr. Garbade, chairman.
(9:00) Treatment of Diabetes Mellitus.
(10:00) Symposium: Splenomegaly As a Diagnostic Problem.
Presentation of Cases—Dr. Schaffer.
Pediatrician's Viewpoint—Dr. Wegman.
Hematologist's Viewpoint—Dr. Levin.
Pathologist's Viewpoint—Dr. Brindley.
(2:00-5:00) Dr. Hansen, chairman.
(2:00) General Pediatric Clinic.
Presentation of Cases—Dr. Gardner.
Discussion of Cases—Drs. Boyd, Wegman, Darrow.
(3:30) Intermission.
(3:40) Present Status of Control of Dental Caries—Dr. Boyd.
(4:20) Dental Problems in Children—Dr. Smith.
(6:30) Dinner (Buccaneer Hotel).

October 30

(9:00-12:00) Round Table: Acute Contagious Diseases of Childhood—Dr. Garbade, chairman.
(9:00) Newer Aspects of Erythematous Diseases, Stressing Differential Diagnosis and Treatment—Dr. Top.
(10:00) Present Status of Immunization Procedures—Drs. Wilkinson, Reading.
(10:45) Intermission.
(11:00) Meningitis: Diagnosis and Treatment—Dr. Top.
(1:00) Buffet Lunch—Dr. Gardner, chairman (Stewart Convalescent Home).
(2:30) Convalescent Care of Orthopedic Patients—Dr. Eggers.
(3:00) Convalescent Care of Rheumatic Fever Patients.
Presentation of Cases—Dr. Gamble.
Discussion of Management—Dr. Hansen.

October 31

(9:00-12:00) Neurological Problems in Childhood—Dr. Wilkinson, chairman.
(9:00) Major and Minor Convulsive Disorders—Dr. Buchanan.
(9:45) Psychiatric Problems in Relation to Convulsive Disorders—Dr. Waterman.
(10:15) Intermission.
(10:30) Presentation of Cases—Dr. Leaton.
(11:00) Specific Problems in Differential Diagnosis of Neurological Disorders in Children—Dr. Buchanan.
(2:00-4:00) Symposium: Encephalitis—Dr. Darrow, chairman.
(2:00) Differential Diagnosis from Pediatrician's Viewpoint—Dr. Davison.
(2:30) Differential Diagnosis from Neurologist's Viewpoint—Dr. Buchanan.
(3:00) Differential Diagnosis from Virologist's Viewpoint—Dr. Pollard.
(3:30) Intermission.
(3:40) Presentation of Cases—Dr. Womack.
(4:00) Latest Methods of Treatment—Dr. Top.
(6:00) Tea (Hotel Galvez).
(7:00) Banquet, Wives Invited (Hotel Galvez).

November 1

(9:00-12:00) Round Table: Abdominal Pain in Children—Dr. Wilkinson, chairman.
Pediatrician—Dr. Davison.
Surgeon—Dr. Singleton.
Pathologist—Dr. Brindley.
Psychiatrist—Dr. Waterman.
Presentation of Cases—Dr. Windrow.
(2:00) Kidney Diseases in Children—Dr. Davison.
Presentation of Cases—Dr. Shepard.
(3:30) Intermission.
(3:45) Speaker to be announced.
(8:00) College of Nursing Commencement Exercises (Stephen F. Austin School Auditorium).

November 2

(9:00-12:00) Joint Session with Nursing Staff—Dr. Hansen, chairman.
(9:00) Prematurity As a Cause of Infant Mortality—Dr. Hansen.
(9:20) Nursing Procedures in the Care of the Premature Infant—Miss Walker.
(10:20) Problem of Home Care of Premature Infants—Dr. Reading.
(10:40) Intermission.
(10:50) Accepted Methods of Infant Feeding—Dr. Garbade.
(11:20) Problems in Infant Feeding.
(11:50) Closing Remarks—Dr. Hansen.

HOSPITALS NEEDING INTERNS AND RESIDENTS

Methodist Hospital, Dallas. Capacity 206 beds. C. B. Fielder, Superintendent (interns desired, July, 1947).

El Paso City County Hospital, El Paso. Capacity 192 beds. George W. Cook, Col., U. S. A., Ret., Superintendent (3 interns for one year term, graduates of class A medical school only).

Nix Memorial Hospital, San Antonio. Capacity 145; admissions 4,988. Miss A. Pearl Smith, Administrator (intern or resident now; application for intern or resident July 1, 1947).

TUBERCULOSIS ASSOCIATION OFFICERS

When the Texas Tuberculosis Association met in Houston on September 16-17, officers were elected for the year as follows: president, F. K. Dougharty, Liberty; first vice-president, Mrs. Joella Terrill

Butler, Wichita Falls; second vice-president, Dr. David McCullough, Kerrville; secretary, J. W. Butler, Texas City; treasurer, Dr. Z. T. Scott, Austin; executive committee, Drs. R. G. McCorkle, San Antonio; J. Edward Johnson, Austin; Elliott Mendenhall, Dallas; James E. Dailey, Houston; Sim Hulsey, Fort Worth; and the president, secretary, and treasurer. The next meeting will be held next year at a time and place to be designated.

The Texas Chapter of the American Trudeau Society, meeting in conjunction with the Tuberculosis Association, elected Drs. E. G. Faber, Tyler, president; James E. Dailey, Houston, vice-president; Elliott Mendenhall, Dallas, president-elect; and Thomas R. Jones, Houston, secretary.

Miss Emmeline J. Renis, Houston, was elected president of the Texas Conference of Tuberculosis Secretaries; Mrs. Gertrude Gardiner, El Paso, vice-president; Mrs. P. R. Watts, Port Arthur, secretary-treasurer; and Miss Renis; Mrs. Gardiner; Mrs. Watts; George H. Craze, San Antonio; Mrs. George Cooksey, Waco; and Miss Sula Fleeman, Fort Worth, executive committee.

STATE UROLOGICAL SOCIETY TO MEET

The Texas State Urological Society, organized on the last day of the Annual Session in Galveston last May, will hold its first annual meeting in Houston at the Jefferson Davis Hospital on December 2, the officers of the society announce. All urologists and other physicians interested in urology are invited to be present. Those who wish to attend should communicate with the secretary of the society at their earliest opportunity.

Officers for 1946 are Dr. Joe C. Alexander, Dallas, president, and Dr. Michael K. O'Heeron, Houston, secretary. Dr. B. Weems Turner, Houston, will be host for the December meeting.

TEXAS ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS

The Texas Association of Obstetricians and Gynecologists will meet November 2 at the Buccaneer Hotel, Galveston, with Dr. Herbert E. Chamberlain, Sacramento, Calif., and Dr. John Rock, Brookline, Mass., as guest speakers. Officers of the society, Dr. Allen McMurrey, Houston, president; Dr. J. E. Kanatser, Wichita Falls, vice-president; and Dr. Julius McIver, Dallas, secretary-treasurer; invite all members of the State Medical Association to attend the annual obstetrical and gynecological program.

Dr. Rock is clinical professor of gynecology at Harvard University, research fellow in obstetrics at Boston Lying-in Hospital, and visiting obstetrician at the Massachusetts General Hospital, Boston Lying-in Hospital, and the Free Hospital for Women. Dr. Chamberlain is a former associate professor of psychiatry at the University of Chicago; one-time director of the Minneapolis Child Guidance Clinic; chief of Child Welfare Services; and U. S. delegate to the sixth and seventh Pan-American Congresses on Child Welfare. He has recently returned from three months in Manila where he was assigned at the request of the State Department upon solicitation of the Philippine government, to outline a federal program for child health and welfare.

A cocktail hour and dinner, to which physicians wives are also invited, will be part of the program.

PROFESSIONS MAY AID PEACE

The medical, dental, and legal professions of any country are only a small segment of its population, but because of their daily contacts, they can exercise a tremendous force toward understanding. Because of this, they become an important force in developing international understanding and contributing toward world peace. We must become better acquainted with one another. We must exchange ideas and technics. We must have sympathy and appreciation for each other's work and problems, and we must make an individual effort to express all this. This is not a one-man job. It is the responsibility of every individual professional man. Toward this end, international conferences and meetings should be encouraged and arranged.—Daniel F. Lynch, D. D. S., F. A. C. D., M. Ann. District of Columbia, Aug., 1946.

HEALTH EDUCATION IN SCHOOL

I regard health education and the program in the schools as so very important because medical service and the health of the people are so dependent upon what goes on in the schools. While we have made great progress in public health, the extension and improvement of medical service requires education to teach people to do things for themselves. A doctor may give his patient good advice, and yet all too often the patient fails to act intelligently in carrying out that advice. . . .

To prevent the serious results of disease through periodic medical supervision or early treatment requires much education, and the doctors cannot do it all. So the future of preventive medicine for the individual must have very much more health education,—education for proper attitudes regarding health and disease prevention, education for good judgment as to when to call the doctor, and for health habits in order to benefit from our modern knowledge of how to improve health and to prevent disease.—Harold H. Mitchell, M. D., Connecticut State M. J., Sept., 1946.

EXPECTANT FATHERS INSTRUCTED

The New Haven, Conn., Department of Health has completed ten years of operation of its Fathers' Councils, a series of meetings for the instruction of expectant fathers in the safeguarding of the health of mother and infant, the *Connecticut State Medical Journal* (Sept., 1946) points out. Approximately 1,100 men have attended one or more meetings, and between 150 and 200 fathers have attended every session of a given course. During the war years the course has been streamlined and cut from six to three sessions, and the number of lecturers from ten to five.

This successful venture has resulted also in a series of parents' meetings in the past two years, following immediately upon the conclusion of each course. Beginning as a single meeting for expectant fathers and mothers jointly for discussion of problems concerning the young child, the session is now held traditionally during May, Child Health Month, and consisted of four meetings this year.

INTERNATIONAL HEMATOLOGY AND RH CONFERENCE

An International Hematology and Rh Conference will be held in Dallas on November 15 in affiliation with the Second Mexican Blood Transfusion Congress, which meets in Mexico City, November 17-25, Dr. Sol Haberman, secretary of the conference, has announced. Any physician or investigator in blood research interested in attending the conference is invited. There is no registration fee, but those planning to be present should register in advance so that housing accommodations may be arranged.

The hematology and Rh conference is being sponsored by Baylor University Hospital, Dallas, and speakers will include Drs. Ludwig Hirszfeld, University of Wroclaw, Wroclaw, Poland; Ignacio Gonzalez Guzman and Eduardo Uribe Guerola, University of Mexico College of Medicine, Mexico City; R. R. Race, Lister Institute of Preventive Medicine, London; Philip Levine, Ortho Research Foundation,

Linden, N. J.; William Dameshek, Tufts College Medical School, Boston; Ernest Witebsky, University of Buffalo School of Medicine, Buffalo, N. Y.; I. Davidsohn, University of Illinois College of Medicine and Mount Sinai Hospital, Chicago; Louis K. Diamond, Harvard Medical School, Boston; and J. M. Hill, Southwestern Medical College and Baylor University Hospital, Dallas.

The morning session of the conference will be held at the Adolphus Hotel with Dr. Hill, chairman of the conference, presiding. The afternoon session will be held in the Medical Library of Baylor University Hospital with Dr. Guerola, president of the Second Mexican Blood Transfusion Congress, presiding.

Reservations for rooms may be made with Dr. Haberman, William Buchanan Blood, Plasma, and Serum Center, Baylor University Hospital, Dallas, before November 5.

CELLOPHANE USED AS WOUND COVERING

A report by N. L. Chistyakov on the use of cellophane in the treatment of wounds appears in the August, 1946, issue of the *American Review of Soviet Medicine*. (See also *Khirurgiya*, No. 7, 1944, pp. 32-37.) The conclusions reached are as follows:

"For the past two years we have used cellophane gauze dressing in treating superficial and deep gunshot wounds in their later stages, as well as open and closed postoperative wounds. We have observed no delay in healing nor any complications which could be attributed solely to the cellophane gauze dressings.

"With the use of this method we were able to perform subsequent dressings with practically no pain or discomfort to the patient.

"At evacuation points a wound can be examined and observed under the cellophane after the overlying gauze dressing has been removed.

"Cellophane used around nerves heals into the wound in most instances.

"Being cheap and economical, cellophane deserves wider use in the treatment of wounds and should be made available at all drug depots."

LIBRARY NOTES

PACKAGE SERVICE

The package library consists of collections of reprints and other periodical material on various subjects, prepared for lending to members of the Association. Requests for packages should be addressed "Library, State Medical Association of Texas, 1404 W. El Paso Street, Fort Worth, Texas." Twenty-five cents in stamps should be enclosed with the request to cover postage and part of the expense of collecting the material. Only one package may be borrowed at a time, and packages are allowed to remain in the hands of the borrower for 14 days.

Packages were mailed from the Library of the State Medical Association during September, to the following:

Dr. Merton M. Minter, San Antonio—*National Health Program* (3 articles).

Dr. J. E. Hogan, Big Spring—*National Health Program* (3 articles).

Dr. F. J. L. Blasingame, Wharton—*National Health Program* (3 articles).

Dr. Elliott Mendenhall, Dallas—*National Health Program* (3 articles).

Dr. Harry A. Tubbs, Fredericksburg—*Intestines, diverticula* (11 articles).

Dr. A. O. McCary, Freeport—*Paralysis, spastic* (5 articles).

Dr. Maurice E. Barrett, Decatur—*Adolescence* (18 articles).

Dr. J. J. Stephen, Robstown—*Ovulation* (1 article).

Dr. W. R. Fickessen, Kerrville—(1 journal).

Capt. J. P. Gibson, Whipple, Ariz.—*Tobacco* (8 articles).

Dr. D. K. Robinson, Rocksprings—*Atomic Energy* (6 articles).

Dr. Masters H. Moore, Tyler—*Liver, function tests* (20 articles).

Dr. L. W. Spikes, Ralls—(1 journal).

Dr. George M. Tulloch, Okmulgee, Okla.—*Am. J. Ophth.* (35 articles); *Arch. Ophth.* (25 articles).

Dr. Carlos A. Slaughter, Sanatorium—*Empyema, tuberculosis* (16 articles).

Dr. T. A. Taylor, Lufkin—*Oxygen, therapy* (16 articles).

Joanna Wells, Jr., Denton—*Medicine, socialized* (12 articles).

Dr. J. T. Boyd, Marlin—*Intestines, diverticula* (17 articles).

Dr. Robert H. McCarty, Lubbock—*Drugs* (11 articles).

Mr. Pete Moore, Henrietta—*Hospital plans* (1 book).

Dr. R. W. Burford, Dallas—*Brain, tumors* (5 articles).

Dr. J. M. Travis, Jacksonville—*Religion and Medicine* (5 articles).

Dr. W. R. Swanson, Taylor—*Blood, groups* (6 articles).

Dr. Holloway Bush, McKinney—*Migraine, therapy* (3 articles); *Skin, tuberculosis* (2 articles).

Dr. T. C. Cole, Huntsville—*Ureters, calculi* (22 articles).

Dr. H. Klapproth, Sherman—*Thyroid, cancer* (10 articles).

Dr. Robert A. Johnston, Houston—(1 article).

Dr. Allen T. Stewart, Lubbock—(1 article).

Dr. Frank Lancaster, Houston—(1 article).

Dr. T. J. McElhenney, Austin—(1 article).

Dr. Milton Davison, Marlin—(1 article).

Dr. L. B. Holland, Wichita Falls—(1 journal).

Dr. S. C. Arnett, Lubbock—*Intussusception* (8 articles).

Dr. P. T. Kilman, Malakoff—*Impregnation* (11 articles); *Diabetes, Insipidus* (4 articles).

Dr. G. E. Glover, Austwell—*Penicillin* (4 articles).

Dr. N. A. Elder, Nixon—*Abscess, subphrenic* (17 articles).

Dr. B. L. Jenkins, Clarendon—*Arthritis, Rheumatoid, therapy* (4 articles).

Dr. P. S. Joseph, Alice—*Anesthesia, metycaine* (24 articles).

Dr. George M. Waddill, Jr., Amarillo—(1 journal).

Dr. Carroll T. Adriance, Galveston—*Varicose Veins* (19 articles).

Dr. W. S. Rhode, Colorado City—*Undulant Fever* (21 articles).

Dr. J. L. Coleman, Sanatorium—*Bronchiectasis* (25 articles).

Dr. Ben B. Hutchinson, Lubbock—*Cornea, ulcers* (4 articles).

Dr. J. E. Hogan, Big Spring—*Curare* (14 articles).

Dr. Fred W. Standefer, Lubbock—*Anesthesia, avertin* (11 articles).

Dr. Ernestine Smith, Amarillo—(2 books).

Dr. J. D. Magee, Abilene—*Nose, polypi* (5 articles).

Dr. F. J. L. Blasingame, Wharton—(2 journals).

Dr. Charles H. Brown, Wichita Falls—*Hodgkin's Disease* (12 articles).

Scott & White Clinic, Temple—(1 journal).

Dr. P. W. Malone, Big Spring—(1 Journal).

Dr. M. Jay McSween, Slaton—*Cold, anesthesia* (10 articles).

Dr. P. L. Allen, Weatherford—*Syphilis and Anesthesia* (24 articles).

Dr. W. W. Coulter, Jr., Sanatorium—*Diabetes and Tuberculosis* (11 articles).

Dr. R. G. Granbery, Marshall—*Surgery* (4 articles).

Dr. Tate Miller, Dallas—*Tropical Medicine* (6 articles).
Dr. Earl R. Cockerell, Abilene—(5 journals).
Evelyn Cutts, San Antonio—*Medicine, socialized* (4 articles).
Marlys Mayfield, San Antonio—*Medicine, socialized* (4 articles).
Gwen Yoachum, San Antonio—*Medicine, socialized* (4 articles).
Billy Gilchrist, San Antonio—*Medicine, socialized* (4 articles).
Anita V. O'Krent, San Antonio—*Medicine, socialized* (4 articles).
Dr. C. B. Batson, Lubbock—*Undulant Fever* (14 articles).
Providence Hospital, Waco—(1 book).
Southwestern Medical College, Dallas—(3 journals).
Dr. Ross Owens, San Antonio—*Condyloma* (7 articles).
Violet Fischer, Houston—*Medicine, socialized* (4 articles).
Dr. Ernest E. Miller, Beeville—(1 journal).
Dr. Edgar Smith, Dallas—(1 book).
Scott & White Clinic, Temple—(3 journals).
Dr. Charles Mims, Mission—*Chancroid* (14 articles).
Dr. J. E. Armstrong, Paris—*Medicine, preventive* (12 articles).
Dr. J. T. Krueger, Lubbock—*Gastro-Intestinal Tract, tumors* (10 articles).

ACCESSIONS

Philadelphia, Blakiston Company—Fleming: Penicillin, Its Practical Application.
Philadelphia, W. B. Saunders Company—Wilder: A Primer for Diabetic Patients, edition 8; Russell, West and Manwell: Practical Malariology.
Springfield, Charles C. Thomas—Braun-Menendez: Renal Hypertension; Liethauser: Early Ambulation and Related Procedures in Surgical Management.
Chicago, A. N. Marquis—Who's Who in America.
Washington, U. S. Government Printing Office—Congressional Directory, 79th Congress, 2nd Session.

SUMMARY

REPRINTS RECEIVED, 1,466.	LOCAL USERS, 45.
JOURNALS RECEIVED, 206.	BORROWERS BY MAIL, 73.
ITEMS CONSULTED, 283.	PACKAGES MAILED, 78.
ITEMS TAKEN OUT, 151.	ITEMS MAILED, 615.

TOTAL ITEMS CONSULTED AND MAILED, 1,047.

MOTION PICTURE FILM LIBRARY

Motion picture films on medical subjects, 16 mm., both silent and sound, some in color, and suitable for either medical or lay audiences, are available for loan to county medical societies, hospital staffs, or individual physicians, on request. Borrowers will be required to pay only the cost of shipment of the films, by express, with insurance, and for any damage to films while in the hands of the borrower.

Requests for films should be addressed to "Motion Picture Film Library, State Medical Association of Texas, 1404 West El Paso Street, Fort Worth 3, Texas." A list of available films, with descriptions, will be furnished on request.

The following motion picture films were loaned by the Motion Picture Film Library of the State Medical Association during September:

Accent on Use (Available through the courtesy of the National Foundation for Infantile Paralysis)—West Texas Hospital, Staff meeting, Lubbock.

Immunization (Available through the courtesy of the Lederle Laboratories, Inc.)—Premedical group, Lamar College, Beaumont.

Malaria—Rotary Club, Arp.

Poliomyelitis, Sister Kenny Method of Treatment of (Available through the courtesy of Dr. Herbert Hipps, Waco)—West Texas Hospital, Staff meeting, Lubbock.

NEWS

Contributions to this department will be appreciated. News should be of general medical interest, such as public health activities, new hospitals, personal items of more than local value, etc. News for a particular number of the JOURNAL should be in the hands of the Editor not later than the fifteenth of the preceding month.

Falfurrias Health Clinic.—Fifty-nine children were examined in a preschool clinic sponsored by the health committee of the Brooks County Home Demonstration Council and held in the Falfurrias elementary school building August 30, reports the Falfurrias *Facts*. Local physicians, nurses, and health workers coöperated in the clinic. Enlarged or infected tonsils were the most prevalent ailment found. The first injection for diphtheria immunization was given to thirty-nine children. Drs. C. H. Otken, Glenn Bartlett, and Paul Toma assisted in the examinations.

Merger of Dallas City and County Health Departments has been approved by Dr. Horace E. Duncan, county health director, as well as the Dallas County Medical Society, City Medical Advisory Board, the Council of Social Agencies, and County Judge Al Templeton, according to the Dallas *Times-Herald*. City Manager V. R. Smitham has indicated that several conferences will be held during the next few months regarding suitable legislation to make the proposed consolidation possible. Any such legislation would provide for a special health department tax, it was pointed out. Dr. Duncan said that he believed those chosen to work in such a consolidated department as is planned should be given assurance of security of employment and placed under civil service. He added that although there would be a single centralized head, it probably would be necessary to maintain specialized personnel for service in the city and in rural communities.

Galveston Health Unit Proposed.—City officials of Galveston are planning for creation of a city health unit with a view to integrating all of the city's health and sanitation activities, reports the Galveston *News*. Establishment of such a unit has previously been advocated by special planning committees and civic groups, but for the first time city officials are formulating specific plans for one. If a proposed budget for the fiscal year is adopted, Dr. John McGivney, acting city health officer, says that a full-time sanitarian will be employed, to serve also as assistant director of the unit. A part-time city health physician and director of the unit will be employed until additional funds become available for a full-time director.

San Angelo-Tom Green County Health Board reorganized recently with four new members, informs the San Angelo *Standard*. Dr. K. B. Round, the only holdover member, was named chairman to succeed Dr. Victor E. Schulze, retiring member who had held the chairmanship since inception of the board. Dr. Round and Dr. F. Leon Hutchins, the newly elected vice-chairman, represent Tom Green County physicians. The board ruled that outdoor serving of food might be permitted provided such service is after sundown only, tables or counters are of concrete or other easily cleaned surface, and food is stored and prepared in a screened building. The procedure for local teachers to follow in securing health certificates was modified so that a physical examination and blood test will be made each year, but evidence of a negative tuberculin skin test or negative roentgen examination will be necessary only once every two years, instead of every year as previously required. The board also passed a ruling directing retail beer establishments to provide toilet facilities for customers.

San Jacinto Memorial Hospital, a 100 bed unit to care for the needs of the Baytown-Goose Creek-

Pelly area, will be erected as soon as conditions permit, as the result of a $1,250,000 gift from the Humble Oil and Refining Company, reports *Medical Record and Annals.* The three story, air conditioned hospital, with provision for a fourth story when needed, will be a memorial to those who served in World War II.

A **Highland Park Hospital** cannot be erected at the site proposed by Dr. Frank Austin, according to a ruling of the local board of adjustment, reports the Park Cities *News.* Dr. Austin planned to build a twelve story, 300 bed hospital on property now occupied by a small medical building and a nursery salesroom, to help care for the urgent need for more hospital facilities in Dallas. Approximately 150 property owners appeared before the board to protest that speeding ambulances would endanger the lives of children and residents and that sirens would disturb their sleep. Dr. Austin was undecided whether to contest the unanimous ruling of the board that the zoning regulations would not be changed to permit erection of the hospital.

Providence Hospital, Waco, expects to conduct a campaign for funds to expand its facilities materially, according to the Waco *Sunday Tribune-Herald.* An executive committee of Waco business men to direct the campaign, which is scheduled for this fall, has already been named. One-third of the money for the proposed hospital addition will be provided by the hospital; application for one-third will be made to the federal government; and Waco citizens will be asked to furnish the remaining one-third. Provision has been made to cover expenses of conducting the campaign for funds so that the entire amount raised will be used for the hospital. The Waco appeals review board, in passing on the campaign, noted that the need for additional hospital beds is the most critical of all of Waco's present needs.

Texas Medical Center.—Houston Shriners opened a campaign September 5 to raise a minimum of $500,000 for construction of a crippled children's hospital at the Texas Medical Center, reports the Houston *Chronicle.* Plans called for a parade, barbecue, and funfest at $100 per ticket with Leo Carrillo and other motion picture celebrities on hand to aid the cause. A five-minute color motion picture made with the coöperation of Howard Hughes Production and Interstate Theatres and starring Pat O'Brien, with some scenes filmed in Houston, was to be shown in each of the thirty theaters in the metropolitan area of Houston in the interest of the campaign. The Arabia Temple of Houston began sponsoring crippled children's work in Houston twenty-eight years ago and is at present operating a clinic at Methodist Hospital. Inadequate hospital facilities in the Houston area have handicapped such work, however, and the Shriners are attempting to obviate this difficulty by making possible a suitable hospital in the new medical center.

Baylor University College of Medicine had two recent additions to the clinical faculty, the Houston *Post* states. Dr. Robert A. Hettig, assistant professor of medicine, comes from the University of Michigan Hospital where he was medical instructor for five years, and Dr. Amy Breyer, assistant professor of clinical pediatrics, was director of the cardiac program of the Connecticut Department of Public Health. Plans for coöperative work with the new Naval hospital are being considered by college officials.

University of Texas.—The inclusive-rate service charge, recently adopted by the Board of Regents of the University of Texas, became effective at John Sealy Hospital on September 1, informs the Galveston *News.* Dr. B. I. Burns, medical director, explained that the service charge represents total cost of serums, nursing care, drugs, operating room, laboratory and other diagnostic examinations, x-rays, and all special therapy treatment which may be ordered by the physician in charge, but does not include private room, ward, or private nurse charges, fever therapy treatment, blood for transfusions, outside telephone calls, personal laundry, or meals or overnight accommodations for relatives or guests. The inclusive-rate service charge totals $38.50 for the first week; $57.50 for two weeks; $68.50 for three weeks; and $1 per day after three weeks, and is based on the average charge for services made to patients during the past year.

Sixty resident physicians who were officers in the Army and Navy during the war are now being trained at the University of Texas School of Medicine, Dr. B. I. Burns, medical director of John Sealy Hospital, has announced through the Galveston *Tribune.* Accredited specialty boards and the Council on Medical Education and Hospitals of the American Medical Association have approved residencies at the University in the fields of anesthesia, dermatology and syphilology, internal medicine, neuropsychiatry, obstetrics and gynecology, ophthalmology, otolaryngology, orthopedic surgery, pathology, pediatrics, radiology, surgery, and urology, Dr. Burns points out.

The venereal disease clinic at John Sealy Hospital was closed to the general public on September 1 because of lack of funds which have previously been allotted the project by the federal government through the State Health Department, informs the Galveston *Tribune.* The duties of the clinic are now limited primarily to teaching purposes, Dr. Chester North Frazier, professor of dermatology and syphilology, states.

The course in physical therapy at the University of Texas School of Medicine has been lengthened from nine to twelve months and entrance requirements have been increased from two years of college work to three years of college and three semester hours of physics, Miss Ruby Decker, technical director of the course, reports in the Galveston *Tribune.* The change was suggested at a recent meeting of the American Physiotherapy Association and most schools are adopting similar programs.

Beauford Jester, Democratic nominee for the governorship of Texas, and Dr. C. O. Terrell, Fort Worth, member of the Board of Regents of the University of Texas, were entertained at luncheon in Galveston in August by several chairmen of departments of the School of Medicine and by Dr. Chauncey D. Leake, vice-president and dean, reports the Galveston *News.* Both Mr. Jester and Dr. Terrell were vacationing in Galveston.

Dr. W. A. Selle, professor of physiology at the University of Texas School of Medicine, delivered a paper at the first postwar meeting of the American Congress of Physical Medicine in New York, September 4-7, informs the Galveston *Tribune.*

Dr. Eric Ogden, professor of physiology at the University, has recently been elected to membership in the New York Academy of Science for his experimental discoveries on hypertension and will visit the academy this fall in connection with his work, according to the Galveston *Tribune.*

Dr. Harvey Slocum, professor of anesthesia at the University, has been requested by the American Medical Association to arrange a technical exhibit on inhalation anesthesia for demonstration at the International Medical Conference in Mexico City, October 6-12, states the Galveston *Tribune.* The exhibit was shown in part by Dr. Slocum and Dr. Kermit O'Neal at the last meeting of the American Medical Association. Dr. Slocum expected to participate in the October 16 celebration in Bos-

ton commemorating the centennial anniversary of the discovery of inhalation anesthesia by Dr. W. T. G. Morton, a dentist and Harvard medical student.

Southwestern Medical Foundation.—Purchase of twenty-four acres of land, mostly owned by the Southwestern Medical Foundation, for location of a 500 bed, $5,000,000 Veterans Administration Hospital has been approved by President Harry Truman, reports the Park Cities *News*. The site adjoins property on which a city-county hospital will be built as well as being next to the Southwestern Medical College property.

Dr. William F. Mengert, chairman of the Department of Obstetrics and Gynecology, Southwestern Medical College, has been appointed general program chairman of the Third American Congress on Obstetrics and Gynecology to be held at St. Louis in September, 1947, informs the Dallas *News*.

Personals

Dr. Charles J. Koerth, Kerrville, has been elected Regent of the American College of Chest Physicians for District 12, which comprises the entire state of Texas.

Dr. McIver Furman, Corpus Christi, has recently been elected a director of the National Tuberculosis Association, reports the Corpus Christi *Times*.

Dr. M. Dennis, general practitioner and local physician for the Santa Fe Railway in Cleburne for forty-one years, has retired, informs the Cleburne *Times Review*. His duties for the railroad have been assumed by *Dr. Tolbert Yater*.

Col. Bloyce H. Britton, El Paso, was recently named surgeon at Middleton Air Material Area Headquarters and commanding officer of the Olmsted Field Station Hospital, Pennsylvania, the El Paso *Times* announces. Colonel Britton has been in active service since 1942 and recently returned from the Pacific area.

Dr. Will Miller, acting director of the Corsicana-Navarro Health Department, has been appointed an assistant collaborating epidemiologist in the U. S. Public Health Service to collect reports in Corsicana of communicable diseases, states the Corsicana *Sun*. The new "dollar a year" appointment, Dr. Miller points out, is merely an effort on the part of the U. S. Public Health Service to secure more complete communicable disease data as similar reports previously were supposed to be sent to Austin and will continue to be cleared there. Dr. Miller urges more conscientious reporting on the part of physicians as only by that means will it be possible to concentrate epidemiologic assistance where it is most needed.

Dr. Fred Harrell, recently returned from military service, has been reappointed city health officer by the Olney city council, reports the Olney *Enterprise*. *Dr. H. C. McKinney*, who had consented to serve as the health officer when Dr. Harrell was called into service, asked to be relieved of his duties when Dr. Harrell returned.

Dr. Howard Dudgeon, Jr., retiring president of the Waco Journal Club, entertained with a stag party at Lake Waco Country Club in August to which eighteen Waco physicians and eight from out of the city were invited, according to the Waco *Sunday Tribune-Herald*. *Dr. Wilson Crosthwait* has assumed presidency of the club, in which members give reviews from current medical journals.

Dr. Minnie L. Maffett, Dallas, first president of the Texas Federation of Business and Professional Women's Clubs and past president of the national group, was honored with a tea September 8 by the Dallas Business and Professional Women's Clubs, informs the Dallas *News*. The Texas Federation has established a fellowship fund in Dr. Maffett's name, the interest from which will be awarded annually to a woman graduate of a Texas medical school for graduate work. Dr. Maffett's birthday, September 9, will be observed as a special Minnie L. Maffett fellowship day each year.

Dr. J. Wilson David, Corsicana, has resigned as a member of the board of education after serving for more than sixteen years, reports the Corsicana *Sun*. Dr. David offered his resignation because his niece will teach in the Corsicana schools this year. The resignation was accepted "with regret" by other board members, who spoke in complimentary terms of Dr. David's service to the public schools.

Dr. Charles B. Truett, Denison, received a fractured shoulder September 5 when he was forced to drive his automobile off the road to avoid hitting another car, according to the Denison *Herald*. Dr. Truett, who was reported not to be seriously injured, was returning from Dallas when the accident occurred. His car was badly damaged.

Dr. Michael K. O'Heeron, Houston, will participate in a panel discussion on urology at the Thirty-Second Clinical Congress of the American College of Surgeons in Cleveland, December 16-20, informs *Medical Record and Annals*.

Dr. and Mrs. George S. True, Big Spring, observed their fifty-eighth wedding anniversary on September 5, reports the Big Spring *News*. A son and five daughters, other relatives, and a number of friends called on Dr. and Mrs. True to extend their congratulations. The only child not present, a daughter residing in Forrest Hills, N. Y., was expected for a visit shortly after the celebration.

Dr. M. C. Hagler, New Braunfels, was struck on the back of the head by an unknown assailant while he slept the night of September 3, informs the New Braunfels *Herald*. Although his injuries were slight, Dr. Hagler awoke at midnight to find himself on the floor in a pool of blood from the wound on his head. A window screen had been cut for entrance to the locked house. Nothing appeared to be stolen.

Marriages

Dr. Wayne H. McClure, Kermit, married Miss Louise Ellett, Jennings-Ordinary, Va., on March 31.

Dr. Robert S. Alcorn, Menard, married Miss Betty Jane Bauer, Cincinnati, recently.

SOCIETY NEWS

Bell County Society

June 5, 1946

(Reported by O. B. Gober, Secretary)

Cirrhosis of the Liver: Possibilities of Treatment—David M. Flett.

Common Eye, Ear, Nose, and Throat Misconceptions—E. R. Veirs.

Bell County Medical Society met at the Kyle Hotel, Temple, on June 5 with twenty-nine members and six guests present. The scientific program indicated above was carried out and there was a discussion of means to help elect candidates favorable to medicine.

Applications for membership of Francis J. Kelly, Lloyd N. Gilliland, Jr., and Wendell Phillips Ward were unanimously approved.

August 7, 1946

(Reported by O. B. Gober, Secretary)

Thiouracil Treatment of Thyrotoxicosis—F. M. Hammond.

The Rheumatic Fever Problem in Texas—V. J. Simmon.

Bell County Medical Society met August 7 at the Kyle Hotel, Temple, with thirty-seven members and eight guests present to hear the program outlined above.

George S. Littell and Leroy M. Cochran were elected to membership upon transfer from Dallas County Medical Society.

President Andrew E. Wiedeman introduced L. M. Cochran, of the Veterans Administration Hospital, who introduced Browley S. Freeman, A. D. Hurt, Dr. Littell, and Robert A. Wise, all of the hospital.

Ector-Midland-Martin-Howard-Andrews-Glasscock Counties Society

August 15, 1946

Ector-Midland-Martin-Howard-Andrews-Glasscock Counties Medical Society met August 15 at Big Spring for a picnic and an address by B. E. Pickett, Carrizo Springs, President-Elect of the State Medical Association. Auxiliary members were also present.

Hidalgo-Starr Counties Society

September 12, 1946

What a General Practitioner Should Know about Glaucoma—Edward W. Griffey, Houston.
Treatment of Renal Colic with Special Emphasis on Crystalluria—Paul R. Stalnaker, Houston.

Hidalgo-Starr Counties Medical Society met September 12 at Edinburg. Edward W. Griffey, Jefferson Davis Hospital and Baylor University College of Medicine, Houston, and Paul R. Stalnaker, also of Baylor University, presented the papers named above.

Hunt County Society

June 18, 1946

(Reported by Harriet Rogers, Secretary)

Hunt County Medical Society met June 18 for a meeting and barbecue given by Dr. and Mrs. S. D. Whitten at their cabin on Club Lake near Greenville. Dr. Whitten presided. About fifty members and their wives heard Holman Taylor, Fort Worth, Secretary of the State Medical Association, discuss the proposed basic science bill and other matters of interest to the Association. Tate Miller, Dallas, also spoke.

July 9, 1946

(Reported by Harriet Rogers, Secretary)

Hunt County Medical Society met July 9 in the City Park, Greenville, for a basket picnic sponsored by the Auxiliary, of which Mrs. B. F. Arnold is president and Mrs. Henry W. Maier chairman of the entertainment committee. Following the meal Mrs. Stephens gave some readings. H. M. Bradford, vice-president, presided. Forty members and guests were present.

September 10, 1946

(Reported by Harriet Rogers, Secretary)

Telling Our Patients—Charles H. Roadman.
Discussion—I. F. Peak.
Effect of the Weather on Heart Diseases and Treatment, Army Decisions—H. M. Bradford.
Discussion—E. T. Crim.

Hunt County Medical Society met September 10 at the Municipal Building, Greenville, with Vice-President H. M. Bradford presiding, to hear the scientific program outlined above.

Lubbock-Crosby Counties Society

July 2, 1946

(Reported by Martin H. Benson, Secretary)

Medical Program of the Veterans Administration—O. J. LaBarge, Lubbock.
Basic Science Legislation—E. A. Rowley, Amarillo.

Lubbock-Crosby Counties Medical Society met at the Plains Clinic, Lubbock, on July 2 with twenty-one members and five guests present. President A. G. Barsh presided.

O. J. LaBarge, of the Veterans Administration, explained in detail the medical program of the Veterans Administration and answered many questions from the members concerning it. President Barsh appointed a committee composed of J. T. Hutchinson (chairman), E. L. Hunt, and Olan Key to meet with the Veterans Administration to work out a fee schedule.

E. A. Rowley, Amarillo, Councilor of the Third District, read and discussed the proposed basic science bill and the medical practice act. He urged that physicians investigate candidates for public office and vote for those who favored the program of the State Medical Association.

James W. Rollo spoke briefly on barbiturates. He had been asked by a federal agent to bring to the attention of the society that physicians are writing a great many prescriptions for barbiturates and that they should use more discrimination.

A communication from the American Cancer Society was read.

August 6, 1946

(Reported by Martin H. Benson, Secretary)

The Rh Factor—O. R. Hand, Lubbock.

Lubbock-Crosby Counties Medical Society met August 6 at the Plains Clinic, Lubbock, with twenty-one members present. Pauline Miller, vice-president, presided. O. R. Hand, Lubbock, presented a paper on the Rh factor which was discussed generally.

The fall meeting of the Third District Medical Society, to be held in Lubbock, October 8-9, was considered and committees appointed as follows: arrangements, F. B. Malone (chairman), Roy Riddle, Emerson Blake; registration, O. R. Hand (chairman), M. M. Ewing; entertainment, R. C. Douglas (chairman), Doyce Clark, Henri Mast. Upon motion by Dr. Mast, seconded by Emerson M. Blake, it was voted to asses each member $10 to defray expenses of the meeting.

E. E. McClure was elected to membership upon application.

Tarrant County Society

September 3, 1946

(Reported by W. P. Higgins, Jr., Secretary)

Plastic Operation for Forming Artificial Vagina in Congenital Absence of Uterus and Vagina; Presentation of Patient—Jack Furman.
Contact Lenses—J. W. Eschenbrenner.

Tarrant County Medical Society met September 3 in the auditorium of the Medical Arts Building, Fort Worth, with forty members and three visitors present. The program as outlined above was presented. The talk by Jack Furman was discussed by A. D. Roberts and William M. Crawford; that of J. W. Eschenbrenner by Gatlin Mitchell, A. E. Jackson, Van D. Rathgeber, and F. L. Snyder.

Jack D. Brownfield was elected to membership upon application, and William W. Wood, Jr., upon transfer from a county medical society in Minnesota.

Tributes were paid Dr. J. D. Collins, who died August 4, and Mrs. Bob Barker, mother of Dr. Bob Barker, who died August 25.

The secretary read a letter from A. L. Roberts, president of the Thirteenth District Medical Society, announcing a meeting of the society for October 24 at Graham.

Tom Green-Eight County Society

June 10, 1946

(Reported by F. T. McIntire, Acting Secretary)

Tom Green-Eight County Medical Society held a call meeting June 10 at the Shannon Hospital, San Angelo, with Grady Mitchell, president, presiding, and F. T. McIntire acting as secretary. A discussion was held regarding the local candidates for State Senator and their attitudes on medical matters.

July 15, 1946

(Reported by R. M. Finks, Secretary)

Tom Green-Eight County Medical Society held a call meeting July 15 in San Angelo with thirty-three members present. Following a report of the legislative committee, Victor E. Schulze moved that the society not publish anything in regard to the State Senatorial race. The motion carried.

The society voted upon motion by W. D. Anderson, second by R. L. Powers, that suitable resolutions be prepared in connection with the recent death of Dr. Charles E. Mays.

September 2, 1946

Tom Green-Eight County Medical Society met September 2 in San Angelo and passed a resolution

endorsing plans for establishment of a city-county hospital in San Angelo. Plans for the facility are hardly past the suggestion stage, the society noted, in expressing its desire to establish "through the city planning board, a city-county hospital in connection with a program of civic improvement, such hospital to provide facilities for low-income people and to include wings for the care of tuberculous, mental, maternity, and contagious patients, respectively, as well as general modern hospital care." Representatives of the society expect to meet with the planning board soon to discuss the proposed hospital.

The society also approved motions to hold a well-child conference, prenatal and postnatal clinics, and an annual crippled children's clinic. The clinics will be held in coöperation with the San Angelo-Tom Green County Health Unit.

Eleventh District Society

October 24, 1946

(Reported by C. B. Young, Secretary)

Early Ambulation following Major Surgical Procedures—R. H. Bell, Palestine.
Diverticulosis and Diverticulitis—J. T. Boyd, Jacksonville.
Urological Anomalies—Max Moulders, Longview.
Common Diarrheas in Infancy—Masters H. Moore, Tyler.
Treatment of Diabetes Mellitus—James A. Greene, Houston.
Cause and Prevention of Sudden Death in the Obstetrical Patient —Harrison W. Johnson, Houston.

Eleventh District Medical Society will hold its fall meeting October 24 in Palestine, with the scientific program outlined above. B. E. Pickett, Carrizo Springs, President-Elect of the State Medical Association, will be guest speaker at the luncheon for all visiting physicians and their wives.

AUXILIARY NOTES

Officers of the Woman's Auxiliary to the State Medical Association of Texas: President, Mrs. George Turner, El Paso; President-Elect, Mrs. Edward C. Ferguson, Beaumont; First Vice-President, Mrs. L. B. Windham, Tyler; Second Vice-President, Mrs. V. M. Longmire, Temple; Third Vice-President, Mrs. R. E. Clark, Memphis; Fourth Vice-President, Mrs. J. E. Hogan, Big Spring; Corresponding Secretary, Mrs. Robert F. Thompson, El Paso; Recording Secretary, Mrs. M. A. Ramsdell, San Antonio; Publicity Secretary, Mrs. J. F. Campbell, Fort Worth; Treasurer, Mrs. Guy Jones, Dallas; Parliamentarian, Mrs. Joe Nichols, Atlanta.

Suggestions for County Medical Auxiliary Presidents.—A printed pamphlet prepared by Mrs. Frank Haggard, San Antonio, chairman of the School of Instruction for the State Auxiliary, entitled "Suggestions for County Medical Auxiliary Presidents" was distributed to state officers, committee members, council women, and county presidents of the Auxiliary by Mrs. George Turner, El Paso, President, in the summer with the recommendation that it be read, studied, and passed on to succeeding officers.

Opening with the motto

"To build on the Foundations of Yesterday
With the tools of today—
The better Medical World of Tomorrow,"

the pamphlet discusses the duties and responsibilities of county presidents, program, program and public relations, legislation, *Hygeia* and physical examinations, benevolent, *Bulletin*, and membership.

"Holding a membership in the Medical Auxiliary is a great privilege, which in turn carries with it many responsibilities to both the medical profession and to our respective communities," the pamphlet declares. "One of the Auxiliary's main objectives is the promotion of health in all its phases. Members must be intelligently informed of Auxiliary aims in order to effectively participate in community, state, and national affairs. Perhaps it never was more important than it is today that our councils should be filled with wisdom, and that the execution of our plans should be more effective."

Another recent publication of the Auxiliary is a historical table showing the names and addresses of presidents, recording and corresponding secretaries, and treasurers of the Woman's Auxiliary since 1918, the year of its organization, originally compiled by the Archives Committee, Mrs. W. A. Wood, Waco, chairman, in 1937, and now brought up to date.

Mrs. W. C. Kimbrough, wife of Dr. W. C. Kimbrough, Denton, and prominent church and civic leader, died in Post, Texas, August 4, 1946, en route home from New Mexico, where she and her husband and another couple had been vacationing. She had been in ill health for several months.

BOOK NOTES

[1]**Shock Treatment and other Somatic Procedures in Psychiatry.** By Lothar B. Kalinowsky, M. D., Research Associate in Psychiatry, College of Physicians and Surgeons, Columbia University, and New York State Psychiatric Institute and Hospital, and Paul H. Hoch, M. D., Assistant Clinical Psychiatrist, New York State Psychiatric Institute and Hospital. Foreword by Nolan D. C. Lewis, M. D., Professor of Psychiatry, College of Physicians and Surgeons, Columbia University. Cloth, 294 pages. Price $4.50. New York, Grune & Stratton, 1946.

This book presents a comprehensive review of the history and development of the modern shock therapies and other somatic procedures. It includes electric shock, metrazol shock, insulin shock treatments, prefrontal lobotomy, nitrogen inhalations, and sleep treatments. In all instances the history and theoretical considerations of the various forms of somatic procedures are carefully discussed and the bibliography is excellent.

In the chapter on convulsive treatments and insulin shock therapy, the technique is carefully outlined and should be a valuable guide for the beginner in these fields. This book should not serve as a substitute for practical experience in the method before attempting treatment. It should be a valuable guide and refresher for the physician who has had instruction but who wants to check up on certain points as he institutes his own therapeutic regime. I was impressed by the fairness to all variations of opinion as to the method of application of these treatments as well as to the basis or theory behind their operation. Dr. Kalinowsky has the distinction of introducing electro-convulsive therapy to the United States and many working in the field received their first instruction at his hands.

This book is recommended without qualification to all physicians in the psychiatric field who are using, or who contemplate using, any of the somatic procedures in the treatment of psychiatric syndromes. Workers in the field will also find the theoretical discussions in the last chapter of the book quite stimulating and I think they will appreciate the scientific attitude of Dr. Kalinowsky, whose final statement is as follows: "Broadly speaking, it can only be stated that shock treatment is an unspecific form of treatment acting as a special form of sedation and stimulation on certain types of abnormal mental activity. A great deal of research is needed, however, to explain how this sedation and stimulation are accomplished. At present we can only say that we are treating empirically, disorders whose etiology is unknown, with shock treatment whose action is also shrouded in mystery."

[1]Reviewed by Jack R. Ewalt, M. D., Professor of Neuropsychiatry and Director, State Psychopatric Hospital, Galveston.

DEATHS*

Dr. Jack Bevil, Hull, Texas, died of congestive heart failure July 24, 1946, in a Beaumont hospital.

The son of Mr. and Mrs. T. B. Bevil, Dr. Bevil was born at Warren, Texas, September 3, 1889. He attended Texas Christian University, Fort Worth; Memphis School of Medicine; and was graduated from St. Louis College of Physicians and Surgeons in 1919. He practiced in Hull for twenty-seven years.

Throughout his professional career Dr. Bevil was a member of the State Medical Association and the American Medical Association, first through Polk County Medical Society and then through Liberty-Chambers Counties Medical Society. He served the Liberty-Chambers Society as president in 1934. He was a member of the Methodist Church, a Mason, and a Shriner.

Survivors include his wife, the former Miss Olive Nugent, whom he married in Houston on February 15, 1917; a son, Dr. Jack N. Bevil, resident surgeon at St. Joseph's Hospital, Houston; a daughter, Miss Dorothy Gene Bevil, Austin; his mother, Mrs. T. B. Bevil, Warren; and three sisters, Mrs. Charles Masterson, Warren, and Mrs. Carl Hickman and Mrs. Ernest Ford, both of Nacogdoches.

Dr. William Roy Cain, Tyler, Texas, was found dead in his bed early on the morning of August 11, 1946, of coronary occlusion.

Dr. Cain was born in Tyler on June 4, 1887, the son of William L. and Lou Anna (Collier) Cain. He attended the Tyler public schools and was graduated in 1909 from the University of Texas School of Medicine, Galveston. He served an internship at the Texas Pacific Hospital, Marshall, and the International and Great Northern Hospital, Palestine. In 1911 he entered general practice at Grapeland, but within about six months he moved to Tyler. He entered military service in 1916, first being sent to the Army Medical College in Washington and then going on active duty with the Medical Corps. He participated in the war in France, for which he received the Purple Heart and was cited for meritorious service by both French and United States commanders. In 1919 he retired from Army service with the rank of captain and returned to Tyler to specialize in eye, ear, nose, and throat. He was ophthalmologist with the U. S. Army Induction Station at Tyler for two and a half years and was city health officer for a number of years.

DR. W. R. CAIN

At various times during his professional career Dr. Cain was a member of the State Medical Association and American Medical Association through Smith County Medical Society. He had been a member continuously from 1942 until his death. He was a member of the Methodist Church, a Mason, and a member of the Dr. Pepper Domino Club, a social organization in which he had been active many years. His hobbies were fishing and gardening.

On March 2, 1911, Dr. Cain married Miss Ann Catherine Radey, of Palestine. Mrs. Cain; a daughter, Mrs. C. J. Montgomery, Houston; two sisters, Mrs. S. B. Newton, Weatherford, and Mrs. Glennie Harris, Washington, D. C.; two brothers, W. L. Cain, Tyler, and E. S. Cain, Glendale, Calif.; and one granddaughter, Susan Hastings Montgomery, Houston, survive.

Dr. Charles E. Collins died suddenly July 2, 1946, at his home in Waco, of coronary occlusion.

Dr. Collins was born July 11, 1888, near Lockhart, Texas, the son of C. P. and Emma (Dudgeon) Collins. His academic education was received in the public schools of Alvin and at Southwestern University, Georgetown. His medical education was obtained in the Medical Department of the University of Texas, Galveston, from which he was graduated in 1913. He then served an internship at Providence Hospital, Waco. After his internship he was house surgeon at Providence Hospital for several years, during which time he organized the clinical laboratory and x-ray department of the hospital. He had been in active practice in Waco for thirty-three years.

DR. CHARLES E. COLLINS

Dr. Collins was throughout his professional life a member of the McLennan County Medical Society, State Medical Association, and American Medical Association. He was a fellow of the American Medical Association and of the American College of Surgeons. He had served McLennan County Society as president, and was a member of the surgical staffs of Providence and Hillcrest Hospitals, Waco, for more than twenty-five years. During World War I he entered the Medical Corps of the U. S. Army as a first lieutenant, spending the greater part of his time on duty with the surgical service at Walter Reed Hospital, Washington, D. C.

Dr. Collins' ingenuity manifested itself early in his professional career. During his service at Walter Reed he removed ureteral calculi by dilating the ureters with over-sized ureteral dilators, considered an unusual procedure at that time by his chief, Dr. F. J. Cotton, of Boston. While Dr. Collins was a general surgeon, he was quite versatile, and was called upon to remove foreign bodies from the stomach and bronchus. In one case he removed a round bead from the bronchus of a child, after a failure to remove it

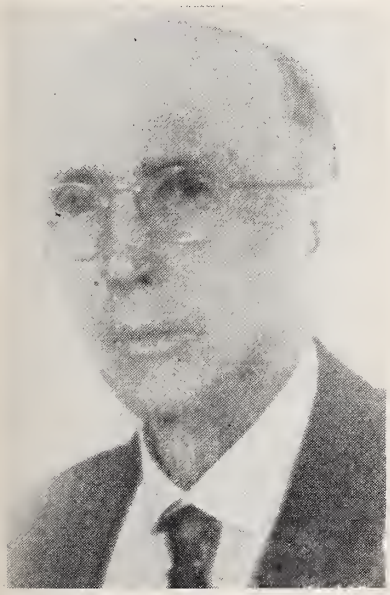
*An obituary ordinarily will not be published more than four months after date of death. Coöperation by county medical society secretaries, friends, and families of physicians in reporting deaths and in furnishing appropriate biographical material promptly is solicited.

with the ordinary bronchoscope, by passing an operating cystoscope into the bronchus and threading a fine wire through the eye of the bead. He was highly regarded as a diagnostician of unusual ability and a general and urologic surgeon of exceptional skill. During the last ten or fifteen years of life he devoted considerable time to fractures of the neck of the femur, and had devised a screw which he made in his own workshop for these fractures. His one hobby besides untiring work was horseback riding. He had won many blue ribbons in local horse shows with his prized five gaited saddle horse, which he had also taught a sixth gait, referred to by Dr. Collins as his W. P. A. gait. When directed by his master to execute the W. P. A. gait, "Chester," the horse, would barely drag one foot after the other. Considered by his associates as one of the most brilliant men in Texas medicine, Dr. Collins also had a charming and genial personality.

Dr. Collins was married in November, 1919, to Miss Sue Spell, of Hillsboro, who died thirteen months later from fracture of the base of the skull. On February 14, 1929, he was married to Mrs. Gladys Cavitt White, of Holland, Texas. He is survived by his wife and his daughter, Shirley Collins; his mother, Mrs. Emma D. Collins, Dallas; three sisters, Mrs. R. H. Parsons, Waco, and Miss Mary Collins and Mrs. H. A. Hill, Dallas; and three brothers, W. H. Collins, Houston; Dr. L. D. Collins, Waco; and Dr. Joe Collins, Waterbury, Conn.

Dr. Charles Edward Mays, San Angelo, died June 20, 1946, following a long illness.

The son of John Milton and Sarah (Fulbright) Mays, Dr. Mays was born November 15, 1861, near New Salem, Texas. He received his academic education at Trinity University, Waxahachie, and received his doctor of medicine degree from Tulane University, New Orleans, in 1885. He returned to New Salem to begin practice, but within four years moved to Wooten Wells, where he remained for three years before locating in San Angelo, his home the remainder of his life.



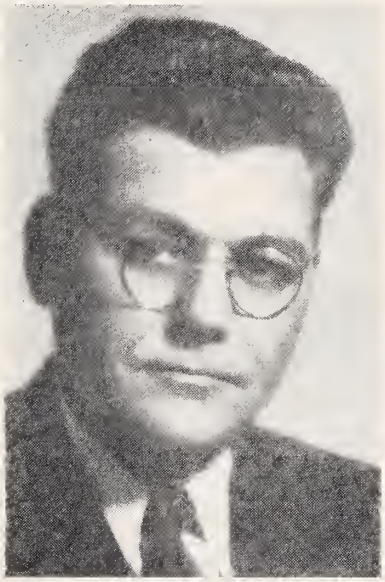
DR. CHARLES E. MAYS

Dr. Mays was a member throughout his professional life of the State Medical Association and American Medical Association and in 1933 was elected to honory membership in the State Association. He helped organize and was a charter member of the San Angelo District Medical Society after its organization. He served as president of his county society in 1905. He was a charter member of the First Presbyterian Church, U. S. A., of San Angelo, an elder and a Sunday school teacher and the church treasurer until a short time before his death. He was a Mason and had been made a lifetime honorary member for his services to the organization.

On October 5, 1887, Dr. Mays married Miss Lulu Wiggins at New Salem. He is survived by his wife; a son, C. E. Mays, Jr., Sweetwater; a daughter, Mrs. David J. Murray, San Angelo; and one brother, J. H. Mays, Jacksboro.

Dr. Claud Earnest Watson, Dallas, Texas, died at a hospital there July 21, 1946, following an operation for gallstones and obstruction of the bowels.

Born in Collin County on April 1, 1891, Dr. Watson was the son of Dr. John T. and Sarah (Bass) Watson. He attended Dallas High School, Terrill Preparatory School for Boys in Dallas, and the University of Texas at Austin prior to being graduated from the University of Texas Medical Branch at Galveston in 1919. He was assistant city health officer in Dallas during 1920 and served a one year internship at Parkland Hospital, Dallas. In 1921 he was instructor in physiology at the University of Texas Medical Branch, and then he began practice in Dallas, where he was active the remainder of his life.



DR. CLAUD E. WATSON

From the time of his graduation from medical school, Dr. Watson was a member of the State Medical Association and American Medical Association through Dallas County Medical Society. He was also a Mason and a Shriner, and enjoyed hunting, fishing, painting, and music.

Much of Dr. Watson's professional career was concerned with the diagnosis and treatment of obscure chronic conditions, principally malaria. He pioneered in the use of bismuth violet as a therapeutic agent for malaria, and he and his assistant, O. O. Cook, Ph. G., synthesized a new chemical, protozidin, which Dr. Watson used successfully in the treatment of malaria and similar protozoal diseases. In 1941 he was invited to spend a month in Mexico City to do additional research in malaria and tropical diseases and to demonstrate his method of treating malaria.

Surviving Dr. Watson are his wife, the former Miss Ora Mae Mitchell, whom he married in 1921 in Dallas, and one son, Claud E., Jr., recently returned from military service in France.

Dr. Enoch Jasper Cook died at his home in Monahans on August 7, 1946, after an extended illness.

Born December 27, 1876, at Mount Pleasant, Dr. Cook was the son of Enoch J. and Eliza Cook. He obtained his medical education at the Memphis, Tenn., Hospital Medical College, and returned to Texas about 1898 to practice. He practiced several years each in Titus, Red River, Lynn, and Hockley Counties before moving to what was then Ector County about 1926. He was responsible for planning and drawing up the petition for organizing Crane County from Ector County at that time. In 1931 he moved to Monahans, where he operated the Northside Hospital

until his retirement in 1944. Since that time he had devoted himself to his real estate business.

From 1931 until his retirement in 1944, Dr. Cook held almost continuous membership in the State Medical Association and American Medical Association, first through Crane-Upton-Reagan Counties Medical Society and then through Reeves-Ward-Winkler-Loving-Culberson-Hudspeth Counties Medical Society. He served on the Selective Service Board for two years and was a member of the Baptist Church.

Dr. Cook is survived by the former Miss Jewel Lacy, whom he married October 9, 1944; four sons, Roy B. Cook, Mount Pleasant; Howard G. Cook, Wilson; and Morris Cook and Richard Cook, Lubbock; three daughters; Mrs. Preston Lee, Sweetwater; Mrs. Charles Burns, Corpus Christi; and Mrs. Lucy Skinner, Lubbock; two brothers, Robert Cook and Ed Cook, Mount Pleasant; two sisters, Mrs. Mary Dickson, Fort Worth, and Mrs. T. N. Harris, Mount Pleasant; ten grandchildren; and one great grandchild.

Dr. John Crafford Holman, Franklin, Texas, died of coronary occlusion June 2, 1946, in a Marlin hospital.

Born March 13, 1869, in Winona, Miss., Dr. Holman was the son of Jesse and Elizabeth (Page) Holman. He received his academic education at the University of Texas, Austin, and his medical education at the University of Texas Medical Department, Galveston, and the Hospital College of Medicine, Louisville, Ky. Following his graduation from the latter institution in 1896, he located in Franklin, Texas, and had been in practice there forty-eight years at the time of his death. For forty-four years he was local surgeon for the Missouri Pacific Railway.

DR. JOHN CRAFFORD HOLMAN

Dr. Holman, from the time of his graduation from medical school until 1943, was a member of the State Medical Association and American Medical Association. He was a member of Brazos-Robertson Counties Medical Society. He had served as president and secretary of his county medical society. He was also county and city health officer a number of years. He was a member of the board of stewards of the Franklin Methodist Church for forty-eight years, mayor of Franklin at one time, a member of Knights of Pythias and of Woodmen of the World.

Survivors include Dr. Holman's wife, the former Miss Julia McMillan, whom he married December 21, 1902, in Franklin, and Dr. John Crafford Holman, Jr., San Diego, Calif.

Dr. Quincy Brown Lee, Wichita Falls, Texas, was stricken with coronary occlusion while on a fishing trip in Wyoming and died in a hospital at Jackson, Wyo., following a second attack three days later on August 13, 1946.

Dr. Lee, son of Dr. and Mrs. James Thomas Lee, was born in Parker County, Texas, on March 18, 1888. Shortly after his birth the family moved to Munday, where Dr. Lee received his early education. After being graduated from high school, he attended Polytechnic Institute in Fort Worth and was graduated from the Medical Department of the University of Texas in 1910. He served an internship at John Sealy Hospital, Galveston, and a residency at Southwestern State Hospital, San Antonio. In 1914 he moved to Wichita Falls, where he made his home until his death. He volunteered for service during World War I and saw active duty as a surgeon overseas before being discharged as a major at the close of the war. Upon his return to Wichita Falls Dr. Lee, Dr. O. B. Kiel, and the late Dr. Everett Jones organized the Wichita Falls Medical and Surgical Clinic, which in 1926 became the Wichita Falls Clinic-Hospital. Dr. Lee was chief surgeon of this institution at the time of his death. He was also division surgeon for the Fort Worth and Denver Railroad and for several oil companies.

DR. QUINCY BROWN LEE

From the time of his graduation from medical college Dr. Lee was a member of the State Medical Association and American Medical Association, first through Galveston and Bexar Counties Medical Societies and then through Wichita County Medical Society. He was at one time president of the Wichita County Society and was chairman of Procurement and Assignment Service for Physicians for Wichita County during World War II. He was a fellow of the American College of Surgeons, a member of the founders group of the American Board of Surgery, and a past president of the Texas Surgical Society. He was a member of Phi Chi medical fraternity and of Alpha Omega Alpha medical honor society. Dr. Lee was a member of the board of stewards of the First Methodist Church in Wichita Falls and a charter member of the Wichita Falls Rotary Club, a Mason, and a Shriner.

Dr. Lee was preceded in death by a first wife, the former Miss Genevive Thompson. He is survived by his second wife, the former Miss Marian Lewis, whom he married in June, 1924; two sons, Dr. James T. Lee, Wichita Falls, and Frank J. Lee, who is entering the University of Texas School of Medicine this fall; two daughters, Mrs. Sam Cantey III, Fort Worth, and Miss Marian Lee, Wichita Falls; one brother, Homer Lee, Wichita Falls; three sisters, Miss Shelly Lee and Mrs. Austin Caughran, both of Munday, and Mrs. Ethie P'Pool, Hereford; one grandson; and one granddaughter.

Texas State Journal of Medicine

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Vol. XLII **November, 1946** **No. 7**

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION AND PUBLIC HEALTH IN TEXAS

The Post Graduate Medical Assembly of South Texas will hold its twelfth annual meeting December 3, 4, and 5, at the Rice Hotel, Houston. This will be the first meeting of the Assembly since the war. As in past meetings the entire scientific program will be presented in a continuous general assembly by visiting guest speakers, all of whom are nationally recognized authorities in their respective fields. The single exception to the general assembly program is that members of the eye, ear, nose and throat section will meet separately for a scientific program presented by guest speakers in this field, as has been customary in past meetings, also.

Immediately preceding the general assembly each day, scientific motion pictures will be shown.

There will be both scientific and technical exhibits.

In the evening of the first day, members in attendance will be entertained by Harris County Medical Society. In the evenings of the second and third days, scientific programs will be presented by guest speakers, preceded by dinners for all in attendance.

Members of the eye, ear, nose and throat section of the Assembly will have clinical luncheons on the second and third days, conducted on the question and answer basis, featuring guest speakers. The Eye, Ear, Nose and Throat Section of the Houston Academy of Medicine will be host to the group on Wednesday evening.

The scientific program of the Twelfth Annual Assembly will be presented in forty addresses by the following fourteen distinguished guests:

Dr. Thomas D. Allen, Rush Associate Clinical Professor of Ophthalmology, University of Illinois College of Medicine, Chicago.

Dr. Henry L. Bockus, Professor of Gastroenterology, University of Pennsylvania Graduate School of Medicine, Philadelphia.

Dr. Guy A. Caldwell, Professor of Orthopedics, Tulane University School of Medicine, New Orleans.

Dr. F. H. Falls, Professor of Obstetrics and Gynecology, University of Illinois College of Medicine, Chicago.

Dr. Deryl Hart, Professor of Surgery, Duke University School of Medicine, Durham, N. C.

Dr. Edwin Parker Hayden, Assistant Surgeon, Harvard Medical College, Boston.

Dr. Paul Holinger, Assistant Professor of Laryngology, University of Illinois College of Medicine, Chicago.

Dr. Wendell L. Hughes, Clinical Professor of Ophthalmology, New York University College of Medicine, New York.

Dr. Lowrain E. McCrea, Associate Professor of Urology, Temple University Medical School, Philadelphia.

Dr. Sidney A. Portis, Associate Professor of Medicine, University of Illinois College of Medicine (Rush), Chicago.

Dr. Richard W. Telinde, Professor of Gynecology, Johns Hopkins University, Baltimore.

Dr. Eugene F. Traub, Associate Professor of Clinical Dermatology, Post Graduate Hospital, Columbia University, New York.

Dr. James L. Wilson, Professor of Pediatrics, University of Michigan Medical School, Ann Arbor.

Dr. Fletcher D. Woodward, Head of the Department of Otolaryngology, University of Virginia Department of Medicine, Charlottesville, Va.

The registration fee for this year's Assembly is $15, which covers all scientific features, dinners, luncheons, and entertainment. This postgraduate educational project is conducted by and for physicians of the Eighth, Ninth, and Tenth Councilor Districts of the State Medical Association, but any physician in

good standing in his county medical society, either in Texas or elsewhere, is welcome. The continuous assembly type of program by guest speakers only has proven its popularity and value as evidenced by record-breaking attendances in the past. This year will be no exception.

Any member of the Association who finds it convenient to take advantage of the opportunity offered by the Post Graduate Medical Assembly will profit scientifically and from the relaxation and stimulating good fellowship which goes with it. Hotel reservations should be made without delay.

Rebates to Physicians on Prescriptions and Appliances.—At a meeting of the Executive Council held in Fort Worth, September 29, 1946, the Public Relations Committee presented resolutions condemning the acceptance by physicians of rebates on prescriptions and appliances as contrary to the Principles of Medical Ethics of the American Medical Association. The occasion for such action was the allegation in certain quarters that such violations of medical ethics by Texas physicians had occurred.

After consideration and discussion of the matter, President Cody referred the resolutions to the Board of Councilors of the Association, to which board, according to the By-Laws, all matters pertaining to medical ethics must be referred for decision.

The Board of Councilors met promptly on the same date, after the adjournment of the Executive Council, and after due consideration amended the resolutions presented by the Public Relations Committee in certain particulars, following which they were unanimously approved. For the purpose of record, the amended resolutions are published herewith:

RESOLUTION ON REBATES TO PHYSICIANS ON PRESCRIPTIONS AND APPLIANCES

"*Whereas*, It has been alleged that some members of the Association have been receiving rebates or commissions on prescriptions and appliances;

"*Whereas*, Such practices are now, and always have been, in violation of, and contrary to, the Principles of Medical Ethics

"*Resolved*, That the Board of Censors of each County Medical Society in Texas is hereby requested to take immediate action to investigate the existence of such unethical practices, and if any of their members are guilty of such practices and refuse to stop, that suitable disciplinary action be taken as deemed expedient; and be it further

"*Resolved*, That copies of these resolutions be sent to the officers of each County Medical Society of Texas."

The following resolutions were adopted by the House of Delegates of the American Medical Association in 1924:

"*Whereas*, It has been brought to the attention of the House of Delegates that the unscrupulous practice of rebates to physicians is being engaged in by various commercial organizations, laboratories, supply houses and in some professional relationships between certain physicians; and

"*Whereas*, All such practices are clearly in violation of the Principles of Medical Ethics; therefore be it

"*Resolved*, That the House of Delegates of the American Medical Association express stern disapproval of the practice by any of the members of its component societies of referring patients to commercial organizations, laboratories or other physicians who advertise to the public and others than the medical profession, who employ so-called steerers or cappers or who pay, or offer to pay, rebates or commissions in any guise whatsoever, or who in any other manner violate the Principles of Medical Ethics of the American Medical Association; and be it further

"*Resolved*, That any member violating these resolutions be subject to such disciplinary action as is deemed advisable by the county medical society in which such physician holds membership; and be it further

"*Resolved*, That the Secretary of the American Medical Association be instructed to send a copy of these resolutions to each state and county society accompanied by a letter to the secretary of each setting forth that all such unethical practices are disreputable and unscrupulous and, if not controlled, may soon besmirch the reputation of the entire medical profession."

Thus, medicine in Texas takes the unequivocal position that its own house must be put in order and demands that its members give not only lip service but strict adherence to the Principles of Medical Ethics, which have been the great moral code of American Medicine throughout the existence of the organization.

Preparations for the 1947 Annual Session of the State Medical Association to be held in Dallas May 5-8 are well under way following a meeting of the Council on Scientific Work October 6, at which time a full discussion was had regarding all features of the program.

Attention is called here to the fact that the Adolphus Hotel has been selected as headquarters for the State Medical Association, and the Baker Hotel, across the street, as headquarters for the Woman's Auxiliary. Actually, many of the activities of the Association will be housed in the Baker Hotel because the continued expansion of our annual session makes it impossible to place all of the activities under one roof. Registration and the scientific and technical exhibits will be at the Adolphus Hotel, as will all the General Meetings and four of the scientific section meetings. The President's Reception and Ball and four of the scientific section meetings will be in the Baker Hotel. The several special state societies which annually meet on the Monday immediately preceding the annual session will hold their meetings in both of the hotels named, about evenly distributed.

County medical societies have been in-

formed regarding the dates of the annual session and the pertinent facts regarding hotel facilities. County society secretaries have been urged to furnish this information to their members, and to urge all and sundry to make hotel reservations now with the hotels of their choice. Again, the dates of the annual session proper are May 6-8, 1947, with only the House of Delegates and the special societies meeting on Monday, May 5.

Apart from the desirability and importance of urging that hotel reservations be made now for the annual session, the principal purpose of this announcement is to call attention to the fact that section officers are now building the programs for their respective sections, and they will appreciate an offer from any member of the Association who has something he would like to present to his fellows, and which he feels should be recorded in the literature. While the program is not definitely closed until the midwinter meeting of the Council on Scientific Work, about the middle of January, prior offers will naturally receive prior consideration. No member who has something to report which he thinks is worth-while should feel any hesitancy in offering a paper to the officers of the appropriate section. It is not a matter of modesty. It is, instead, his responsibility to make such offer. And if it is declined because it does not fit in with the program planned, he need feel no compunction.

For the convenience of members who wish to offer papers for the scientific program of the 1947 annual session, the names and addresses of the section officers are published herewith.

OFFICERS OF SCIENTIFIC SECTIONS

MEDICINE

Dr. James A. Greene, Chairman, Box 156, Baylor University College of Medicine, Houston.
Dr. Raymond Gregory, Secretary, University of Texas School of Medicine, Galveston.

SURGERY

Dr. Walter G. Stuck, Chairman, 1426 Nix Professional Building, San Antonio.
Dr. Cornelius Olcott, Secretary, Harlingen.

OBSTETRICS AND GYNECOLOGY

Dr. G. H. Beavers, Jr., Chairman, 1408 Pennsylvania, Fort Worth.
Dr. W. P. Devereux, Secretary, 3814 Fairmount, Dallas.

EYE, EAR, NOSE AND THROAT

Dr. R. E. Parrish, Chairman, 527 Medical Arts Building, San Antonio.
Dr. Oscar Marchman, Jr., Secretary, 816 Medical Arts Building, Dallas.

RADIOLOGY AND PHYSIOTHERAPY

Dr. L. M. Garrett, Chairman, 612 Medical Professional Building, Corpus Christi.
Dr. H. E. Whigham, Secretary, 412 South Main Street, McAllen.

PUBLIC HEALTH

Dr. Elliott Mendenhall, Chairman, Medical Arts Building, Dallas.
Dr. B. M. Primer, Secretary, 2709 Rio Grande, Austin.

CLINICAL PATHOLOGY

Dr. Charles Phillips, Chairman, Scott and White Hospital, Temple.
Dr. Ellen D. Furey, Secretary, 925-30 San Jacinto Building, Beaumont.

PEDIATRICS

Dr. J. H. Park, Jr., Chairman, 3720 Fannin Street, Houston.
Dr. Harold T. Nesbit, Secretary, Medical Arts Building, Dallas.

Committee on Library Endowment.—For a number of years there has been a Committee on Library Endowment of the State Medical Association but without specific authorization in the By-Laws; in other words, it has been a special committee, appointed at the will and pleasure of the President. The House of Delegates at Galveston last spring, adopted a recommendation of the Library Committee of the preceding year that provision be made in the By-Laws for a standing committee of five members, appointed on an overlapping term of office basis, in order that there may be continuity of policy and objectives in the work of the committee. The By-Law pertaining to the matter states that:

"The Committee on Library Endowment shall consist of five members. The members of the first committee shall be appointed for one, two, three, four, and five years, respectively, and thereafter the President-Elect shall appoint to fill vacancies created by expiration of term of office. These appointments shall be confirmed by the House of Delegates and shall be considered at the time of election of officers. The chairmanship of the committee shall be determined each year by the President-Elect when he assumes the office of President. It shall be the duty of this committee to secure donations and endowment funds for the Texas Memorial Medical Library Association, and to keep the membership of the Association acquainted with the services offered by the Library to members and the public, and its need for continuous greater development and greater services. This committee shall present to each annual meeting of the House of Delegates a report covering its activities during the preceding year."

President Dr. Cody, cognizant of the importance of the matter, and taking into account the fact that the Library is under the supervision and direction of the Board of Trustees, requested nominations from the Board for the personnel of the committee. The following committee was appointed from a list of fifteen nominees, submitted by the Trustees to the President, in response to his request:

Dr. V. R. Hurst, Longview, Chairman (five years).
Dr. Walter G. Stuck, San Antonio (four years).
Dr. O. B. Kiel, Wichita Falls (three years).
Dr. J. C. Terrell, Stephenville (two years).
Dr. F. T. McIntire, San Angelo (one year).

The special Committee on Library Endow-

ment of last year made another notable recommendation in its report to the House of Delegates, which was unanimously adopted, as follows:

"Immediately that the war emergency is over and building materials become available, a modern, fireproof building should be erected. The contents of our Library now are highly valuable, and no amount of insurance could replace them if they were destroyed by fire."

The emergency pointed out in the recommendation quoted is an immediate challenge to the newly created Committee on Library Endowment, the Board of Trustees, and the Association as a whole. Every day's delay in providing a fireproof building to house the Library of the Association courts a disaster that could not be compensated for immediately with any amount of money. Time alone would permit the re-accumulation of library material such as now makes possible an outstanding package service of the best in literature to physicians of Texas on any subject in medicine.

It will be necessary, of course, to determine the type and size of building needed for the Library, allowing for continual expansion and growth, and then to determine what it will cost. These factors are chiefly the responsibility of the Trustees, but may be shared by the Committee on Library Endowment.

Methods and means of raising the money needed for the construction of a building, and its equipment, is the function particularly of the Committee on Library Endowment. Special committees in the past have appealed for donations from members and county medical societies but without a specific goal. There is now in a fund designated as the "County Medical Society Library Building Fund" the sum of $1,628. A statement of what it would cost to build a fireproof building that would be a credit to the medical profession of Texas could be nothing more than a guess under present conditions. The time for guessing has passed. It is fervently hoped that the newly created Committee on Library Endowment will receive the full and enthusiastic support of members of the Association for its present greatest need—a monumental, fireproof building to house its Library.

Army Motion Picture Films Available.—Through the courtesy and coöperation of the Education and Training Division of the Office of the Surgeon General of the U. S. Army, Washington, D. C., arrangements were made recently whereby thirty-one medical motion picture films, property of the Medical Department, have been made available through the State Medical Association of Texas, for loan on request to members of the Association and other professional groups and individuals in Texas, subject to certain regulations, as follows:

1. The film will be shown only to members of the medical profession or allied scientific groups who are bound by professional ethics.
2. No admission fee of any sort will be charged for the viewing of the films, and no reproductions of the film in whole or in part will be made.
3. The film will be shown only to the group and for the purpose indicated on this request.
4. Suitable projection equipment and the services of a competent motion picture operator will be provided by the borrower, and the War Department will not be called upon to furnish these facilities.
5. Cost of shipment of the film will be defrayed by the borrower.
6. The borrower will reimburse the Government for such damage to the film while in his possession, as may necessitate the replacement of the print or any part thereof.
7. Film will be returned the day after the last showing for which borrowed.

It should further be pointed out that all of the films are 16 mm., sound, to be projected on sound equipment only.

A list of these films, with a description of each, is published in this number of the JOURNAL (p. 439), with full information regarding the regulations under which they may be borrowed, and the procedure to be used and information to be furnished in connection with requests for loans. This information has been incorporated in a pamphlet listing, in addition, some forty-seven other professional films which are now available in the Motion Picture Library of the State Medical Association, which will be promptly furnished in response to requests addressed to the Library, 1404 W. El Paso Street, Fort Worth 3, Texas.

Announcement is here made of the availability of a pamphlet listing thirty-two health educational motion picture films for lay audiences, in the Library of the State Medical Association, which may be secured on request to the Library.

Motion picture films on medical subjects for both lay and professional audiences are constantly being acquired by the Library, so it is difficult to keep printed lists up to date. Acquisitions of films are announced promptly in the JOURNAL.

Appreciation is hereby expressed to the Education and Training Division of the Office of the Surgeon General of the U. S. Army for the splendid coöperative arrangement announced here, making motion picture films of the Medical Department available to physicians and allied professional groups in Texas.

High School Debates on Compulsory Sickness Insurance.—The Committee on Debate Materials and Interstate Coöperation of the National University Extension Association

selected as the debate topic for the year the following subject: "*Resolved:* That the federal government should provide a system of complete medical care available to all citizens at public expense." The University Interscholastic League of Texas has selected the same topic for debate by high school students of Texas.

The Public Relations Committee of the State Medical Association anticipated a need for information for these debaters, and through the coöperation of the National Physicians Committee and the Council on Medical Service of the American Medical Association, has assembled material in the Library of the State Medical Association, 1404 W. El Paso Street, Fort Worth 3, Texas, to send out as many as 250 packages at one time. The packages will be loaned for a period of two weeks, without charge, except for return postage, to high school students participating in the debates. The material assembled consists of 100 Debaters Packages, prepared by the National Physicians Committee, and 150 copies of a 119-page booklet entitled "Voluntary Health Insurance *vs* Compulsory Sickness Insurance," which is a compilation by the Council on Medical Service of the American Medical Association of articles from various sources.

Announcement has been made of the availability of these packages for loan on request by high school students, in a circular letter addressed by the Public Relations Committee to superintendents of independent school districts and rural high schools of Texas, under date of October 29. At this writing, requests for the material are already being received in large numbers by the Library.

The Director of Speech Activities of the University Interscholastic League is publishing a notice announcing the availability of this material in the November number of the *Interscholastic Leaguer*, which goes to some 25,000 teachers in Texas.

The wide publicity given this effort to furnish debaters with facts on the negative side of the question may produce a demand greater than can be met with the packages so far assembled; but if so, every effort will be made to secure more material for the purpose. The opportunity to give high school students authentic information on this subject, which may have tremendous influence on whether we shall remain a democracy with free, unfettered institutions or change to a regimented bureaucracy, is one that must not be neglected.

Dr. W. B. Russ Resigned.—On August 16, 1946, Dr. W. B. Russ, of San Antonio, tendered his resignation as Trustee of the State Medical Association of Texas. President Dr. C. C. Cody regretfully accepted the resignation, to become effective October 15. The President insisted that Dr. Russ remain in office until the later date because of important matters then under consideration by the Board, which deserved the benefit of his seasoned judgment and experience.

Any encomium for the services of a trusted official seems trite when compared with the years of sacrifice and devotion given the cause of medicine by Dr. Russ. Dr. Russ was a member of the provisional House of Delegates of the State Medical Association, in 1902, which considered and acted upon the then proposed reorganization plan of the American Medical Association, as it is now constituted. He was a member of the Committee on Public Policy and Legislation of the State Medical Association when the Texas Medical Practice Act was passed; a member of the first Board of Councilors of the Association, serving as Councilor of the Fifth District from 1903 to 1910; and the forty-first President of the State Medical Association, being unanimously elected to that office in 1909 at the age of 35. He was appointed a Trustee in 1920, to fill the unexpired term of Dr. C. E. Cantrell, deceased, and had served continuously in that capacity until his resignation became effective in October.

As in the case of others who have served the Association notably over extended periods of time, the advice of Dr. Russ will always be sought and used by those who carry on in official capacities.

Dr. Merton M. Minter, of San Antonio, chairman of the Committee on Public Relations, was appointed by President Dr. Cody to fill the vacancy on the Board of Trustees caused by the resignation of Dr. Russ. Dr. Minter is well and favorably known to the medical profession of Texas, principally because of his splendid services on the Public Relations Committee since that committee was created. He was a co-chairman of the committee before it became a standing committee, as now provided in the By-Laws. Dr. Minter has exhibited leadership, courage, and excellent judgment in Association matters, which are qualities that will stand him in good stead as a Trustee. Dr. Cody has chosen wisely in his selection of a successor to Dr. Russ.

Fiscal Year State Medical Association Changed.—The fiscal year of the State Medical Association of Texas has been changed to the period, January to December, both months included. Heretofore the fiscal year has been from May to April, both months included. Thus the fiscal and the membership year coincide. The trustees are hopeful that

through this change some of the previously existing confusion will be eliminated.

It is hoped that county society secretaries will be able to push the collection of 1947 dues, so that a great majority of our members will have paid the same by the time the books are closed, December 31. It will help a great deal if this can be done and the money relayed to the State Secretary without delay. Membership is not complete until the State Secretary has received the membership fee.

As a matter of fact, membership has always ceased on January 1 if dues for the year have not been paid by that time, but members have had until April 1 to adjust their memberships. That is the date county society reports are due, and the books were not closed until the end of April. On January 1 of 1947, the issue will be clearly drawn through the process of closing the books, although county society secretaries will still have until April 1 to make their reports. This may have a definite bearing on medical defense. A member to be entitled to medical defense must have been a member when the incident occurred upon which suit is based, and must be a member at the time suit is filed. Thus the interim between January 1 and the date a member actually pays his dues will be wiped out for those who do not pay by January 1, at least so far as medical defense is concerned.

We trust our members will bear this matter in mind, and that they will help the secretaries of their respective county medical societies to do their bookkeeping job in time. It must be remembered that, for the most part, county society secretaries are unpaid servants, and that, as a rule, they are just as busy as are the other members of their societies. They are entitled to help, and should have it.

CURRENT EDITORIAL COMMENT*

†**Cooperative Hospitals in Texas.**—The last Legislature passed the Senate Bill 181, empowering communities of 2500 population or less to organize hospitals. Since that time considerable interest has been manifest in rural areas, and several groups have been formed to promote and erect such hospitals. There are at present on file with the Secretary of State nineteen charters for coöperative hospitals in Texas. It is interesting to note that ten, or more than half of these, lie in West Texas where the population is more widely scattered than in other portions of the State.

The coöperative hospital is usually fostered by an interested group, headed by an individual who usually aspires to be the manager of the hospital. The building fund is solicited primarily from rural families who intend to use the hospitals. Donations from others interested and even memorial funds are sometimes given. The building fund is secured, however, in most instances by collecting from each member family a life membership, ranging from fifty to one hundred dollars. With this fund the group plans to build and equip the hospital. This done, an annual assessment is levied against each member, the most usual amount being twenty-five dollars per year per member. In return for this sum the member will get medical and surgical attention at the hospital by physicians employed on a salary by the hospital corporation. Some groups hope that hospitalization may be furnished also, but most are promising only surgical and medical service and then hospitalization at about half the prevailing rate in standard institutions.

There are some advantages to such a method of organizing a hospital. Every one recognizes the need for better rural hospital and medical services. By pooling funds, a rural area may be able to obtain these, where before there was not sufficient inducement for a young physician to move to the area. Modern physicians need modern hospital equipment, laboratories, x-ray, etc., to practice modern scientific medicine. Therefore, this method offers hope to rural areas to obtain better service, and there should be a better distribution of medical and hospital care as a result. If this is done by the community on its own and the hospital maintained as a local affair, there will be less interest in compulsory prepayment medical service and socialized medicine.

From the standpoint of the State Medical Association this procedure presents many disadvantages and difficulties. These stem from the fact that the method of organizing and the proposed plans for maintenance of such hospitals are contrary to the tenets of medical ethics.

1. The hospital organization openly advertises for members and openly solicits them.

2. There is no free choice of physicians by the members. They must employ the physicians hired by the hospital, and members make no contract with the physician.

These bad features are not insurmountable, as will be shown later.

A second item that presents a problem is

*This department of the JOURNAL presents editorial comments on current items pertaining to the science, art and practice of medicine, contributed by members of the State Medical Association and scientists closely associated with the medical profession of Texas. Invitation is hereby extended to any member of the State Medical Association of Texas to submit such discussions for this department. The discussions should not be more than 500 words in length.

†EDITOR'S NOTE.—This article was a report prepared and presented for the Public Relations Committee of the State Medical Association to the Executive Council of the Association at Fort Worth, Sept. 29, 1946. It was unanimously approved by the Council as presented.

the matter of cost. Can a small community build, equip and maintain a hospital that will guarantee first-class, up-to-date service? General Bradley, of the Veterans Administration, is authority for the statement that a first-class hospital cannot be erected and equipped for less than $24,000.00 per bed. That, of course, is at prevailing costs of labor and materials. Times have changed. In the past hospitals have been built at a cost ranging from six to ten thousand dollars per bed. Even at those figures, how can a community build, equip and maintain a good hospital at a rate of fifty to one hundred dollars per family, especially in an area where the number of families is definitely limited? Once erected and equipped, the hospital must be maintained. This is no small item. It entails expert administration and constant expense, which is as unrelenting as taxes. Hospital management is a highly technical specialty, and it is doubtful if many of the promoters who aspire to such a position will succeed in the venture.

There is a third danger in this movement. It may be remote or only in the imagination of some doctors. However, at a recent national conference on coöperative health plans at Two Harbors, Minnesota, the basic theme of discussions was "Medical Care belongs to the Consumer." The statement was made by one speaker "that as a matter of human right, medical service belongs to the consumer; the producer, i. e., the physician, cannot furnish the leadership that the consumer can in the distribution of medical service, the maintenance of its quality and its character." This philosophy is being preached to consumer groups; the community hospital is such a group and the idea will be fostered of making the physicians it employs merely tools in their system of distribution. Physicians have always maintained that they know best what medicine the patient needs. Furthermore, they still insist and maintain that they know more about the protection of public health, the maintenance of high medical standards and the proper distribution of medical care than any consumer group.

After this study of the problem, our Public Relations Committee recommends:

1. Conferences with rural farm groups, indicating our willingness to coöperate in any plan to improve rural health.

2. Approval of the community hospital movement if such hospitals can be maintained according to standards of medical ethics. This will necessitate free choice of physicians, abandonment of promotional schemes by solicitation and advertising. It will probably mean a contract between physicians and members on a definite fee schedule.

3. Insistence that the community hospital as proposed is on dangerous ground because it is in effect a corporation practicing medicine and in doing so performing an illegal act.

4. Directing the attention of rural communities to the availability of current prepayment plans for hospitalization, medical and surgical service, at lower cost than coöperative hospital plans offer.

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Lubbock, Texas.

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REDUCING THE MORBIDITY AND MORTALITY IN SURGERY OF THE COLON

ALBERT O. SINGLETON, M. D.
and
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GALVESTON, TEXAS

Extending the scope of operative resection of the colon (fig. 1) as well as reducing the number of operations, seems to be the goal of those who are doing this type of surgery, and it is rather remarkable how much has been accomplished in these endeavors.

It has not been very long since resections of parts of the colon for neoplasms was done only in a very limited number of cases with a very high mortality, while at the present time many patients who were formerly considered inoperable are successfully resected, and in the place of multiple stage operations, one single operation has been able to accomplish the same results with much less morbidity as well as a lower mortality rate. The exteriorizing operation advocated by Mikulicz[5] as far back as 1903 was a forward step in abdominal surgery. This exteriorization procedure was done to prevent the dreaded peritonitis which usually followed this surgery. This exteriorization procedure has been rather uniformly practiced since the days of Mikulicz until recently. It is true that for many years one stage resection and anastomosis for removal of the right half of the colon has been practiced with increasing success, but the primary resection and anastomosis of the left half of the colon was considered practically impossible of success. Even now many surgeons, including the Lahey Clinic group[3] favor the principle of exteriorization.

A number of writers have reported with caution the extending of the one stage procedure to the left half of the colon and even to the entire large bowel. Among these may

Read before the Section on Surgery, State Medical Association of Texas, Anual Session, Galveston, May 8, 1946.

be mentioned, Schoemacher,[9] Campbell,[1] Wilkie,[15] Whipple,[14] and more recently Wangensteen,[13] Meyer,[4] and others.

The idea of reducing the number of operations a patient may have to undergo where a maximum of safety to the patient is still observed has appealed to us as well as to almost everyone else, and our practice along these lines has been followed by very encouraging results.

The reduced mortality in colon surgery has been rather astounding as indicated by the reports from various clinics. Coller[2] recently reported a resection mortality of 4 per cent on 112 patients. Pemberton[7] from the Mayo Clinic reported a mortality of 15 to 20 per cent before 1934, while in the last five years the rate has dropped to around 5 per cent in resectable cases. Similar mortality percentages for the past five years have been reported from the Lahey Clinic, and there has been even a lower mortality rate for the last three years.

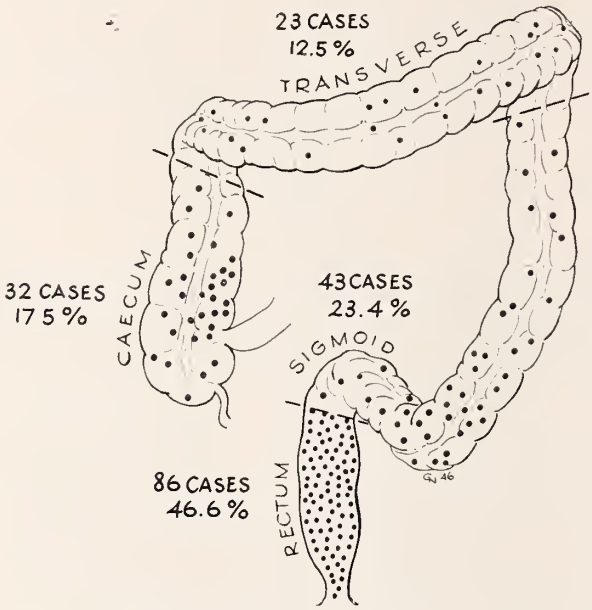

FIG. 1. Distribution of 184 cases of cancer of the large bowel, 1932-1946.

It is incumbent upon us to examine the situation and try to explain what factors have contributed to this marked improvement.

1. *Earlier diagnosis* is probably being achieved now and the patient is being treated before he reaches a far advanced state of malignancy. Unfortunately our records show that early diagnosis is not near the stage where we can say that it has made a marked difference. Too many patients are received in advanced stages of carcinoma of the colon even though the roentgen ray is a valuable adjunct to positive diagnosis.

From the accompanying tables it will be seen that 190 patients with diseases of the colon are reviewed. Malignancy is responsible for 184 of these. The number of inoperable cases was regrettably high, being 38.5 per cent, as is also true in most hospitals with a large population of free patients who are received in a more advanced stage of disease than private or pay patients. If we were to consider our private patients alone, our records would be better. There has been less improvement in our records of earlier diagnosis than in our records of improvement in mortality and morbidity.

TABLE 1.—*Neoplasms of the Large Bowel, 1932-1946.*

	No. Cases	Resectable %	Inoperable %
Total	184	61 5	38.5
Colon (Exclusive of Rectum)	98	58	42
Rectum	86	65.1	34.9

2. *Circulation of the bowel* with reference to the principles of surgery is another important factor. The realization that only viable bowel with adequate circulation will live and unite when sutured together is all important. The colon is not so richly supplied with blood as the stomach or even the small intestine; therefore, the preservation of important arteries must be kept in mind when one resects the colon and does an anastomosis. We have previously published a study of the anatomy of the colon which we think is of value for any surgeon doing colon surgery.[10]

TABLE 2.—*Resection for Cancer of Right Colon (Cecum, Ascending Colon, Hepatic Flexure and Transverse Colon), 1932-1946.*

	No. Cases	Percentage of Total Cases	No. Deaths	Percentage Mortality
Total	51			
Inoperable	24	47		
Palliative	15			
Resectable	27	53	4	14.8
One Stage Resection and Anastomosis	20		3	13.5
Antecedent Proximal Colostomy	1			
Two Stage Resection and Anastomosis	6		1	16.6
Modified Mikulicz Procedure	1		0	0
Obstructed	8	15.7		

3. *Improved abdominal incision* is a factor in success. Anatomical incisions are advantageous in any abdominal surgery. The transverse types of incisions for resection of the colon are less apt to give trouble and at the same time they give better access to the pathologic areas than vertical incisions. One of these incisions is illustrated by figure 2.

4. *Preparation of the patient for operation* is the fourth contributing factor. Many

of these patients will be considerably starved because of the long interference with digestion and function of the bowel. Some have lost blood and become anemic; others have become afraid to eat and have lived on a starvation diet with a very low vitamin content. A large number will have had a partial obstruction for a considerable length of time. Preoperative preparation consists of proper feeding and proper vitamin administration.

TABLE 3.—*Resection for Cancer of Left Colon (Splenic Flexure, Descending and Sigmoid Colon), 1932-1946.*

	No. Cases	Percentage of Total Cases	No. Deaths	Percentage Mortality
Total	47			
Inoperable	17	36.2		
Palliative	12			
Resectable	30	63.8	4	13.3
Resection with Primary Anastomosis	8		0	0
Antecedent Proximal Colostomy	1			
Modified Mikulicz Procedure	14		3	21.4
Anterior Resection with Abdominal Colostomy	8			12.5
Obstructed	14	25.9		

This is particularly important in the avoidance of postoperative delirium or delirium tremens which is fairly common following operations upon the colon. Again, the use of drugs such as the sulfa groups in reducing the bacterial count in the bowel, at least theoretically, should play an important part in this work.[8] We have not had experience sufficient to give such drugs any value ourselves but others attribute much of their success to their use. If one does not allow his faith in these drugs to lessen his enthusiasm for surgical principles, they certainly should be given a trial.

5. *Deflation and putting the alimentary tract at rest* following operation and until the natural powers of the tissues to heal have occurred is more important than all other factors. Just as a fractured arm or leg heals better when put in a splint, so

TABLE 4.—*Resection for Cancer of Colon Exclusive of Rectum, 1932-1946.*

	No. Cases	Percentage of Total Cases	No. Deaths	Percentage Mortality
Total	98			
Inoperable	41	42		
Palliative	27			
Resectable	57	58	8	14.1
Primary Resection and Anastomosis	34		4	11.7
Multiple Stage Procedures	23		4	17.4
Obstructed	22	22.4		

the intestine will heal more satisfactorily if it is temporarily put at rest. This is accomplished by preventing gaseous distention in the intestines.[12] Gaseous distention has always been the greatest single factor in preventing the healing of a sutured bowel. This naturally is a mechanical problem. Distention not only is apt to cause leaking at the suture line but results in impaired circulation to those areas of the bowel where healing is expected. It seems certain that of all the different things which have been contributing to the success of abdominal surgery, none has been as important as the principle of keeping the alimentary tract deflated during recovery. We feel quite sure

FIG. 2. Transverse abdominal incisions. These are preferable to vertical incisions in resection of any part of the large bowel.

when an abdominal operation with resection of part of the alimentary tract has been done that peritonitis will not occur and union will occur in all instances in which distention is avoided. For many years we have felt so confident in the efficacy of gastric suction (after the Wangensteen method) to prevent distention of the bowel that we have completely discarded enterostomies, both in the small bowel and in the large bowel. It goes without saying that gastric suction if

TABLE 5.—*Resection of Colon with Primary Anastomosis, 1932-1946.*

	No. Cases	No. Deaths	Percentage Mortality
Cancer of Right Colon	20	3	13.5
Cancer of Left Colon	8	0	0
Benign Lesions of Colon	5	0	0
Total	33	3	9

successful should be instituted before the operation starts and should be continued until peristalsis is restored, which usually means in alimentary tract surgery, four to five days. It should be remembered that the tube used should be no smaller than a size 16 and that it should have a leaded end with many holes. It is important that it should not extend past the pylorus. If the tube does not extend past the pylorus, bile and pan-

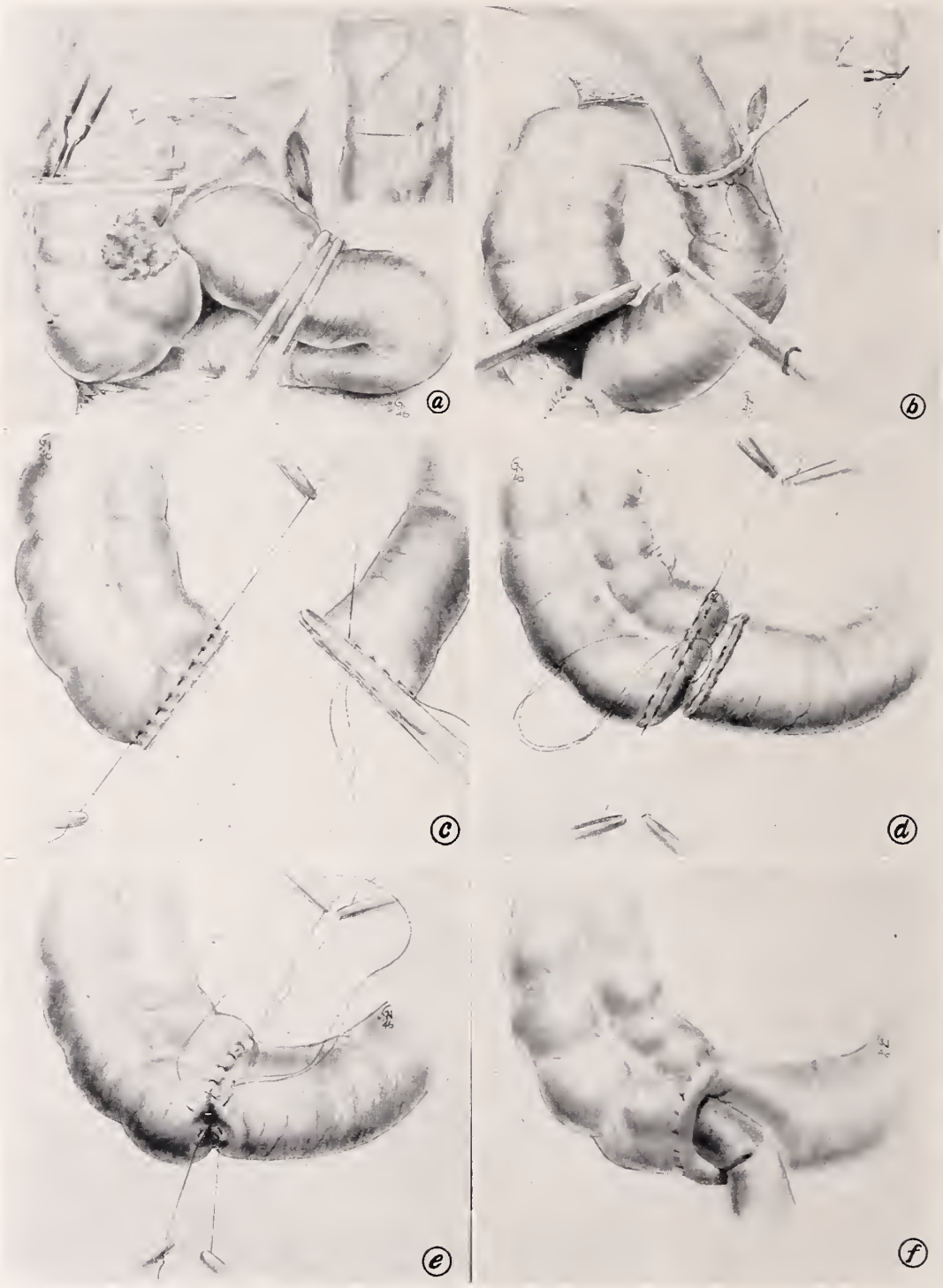

FIG. 3. a. Resection of cecum in the presence of obstruction with cautery between clamps.
b. Following resection, large rubber tube securely placed in proximal end of ileum, leaking being prevented by rubber clamp until purse-string suture is securely tied. The proximal intestine is stripped, emptying the intestine through the tube into a basin on the floor.
c. First step of modified Kerr anastomosis. Basting stitches inserted.
d. Second step, modified Kerr anastomosis. Posterior sero-muscular continuous suture.
e. Completing the anastomosis. The continuous suture is continuous anteriorly as a sero-muscular stitch.
f. Basting stitches removed, anastomosis completed, patency of lumen assured.

creatic fluids may still serve a useful purpose in fluid and electrolytic balance during this period of alimentary tract rest. It should be frequently checked to see that it is functioning. Distention should not occur in these patients postoperatively.

6. *Maintaining the patient's nutrition, fluids, and electrolytes* during the period of alimentary tract starvation must be carefully attended to. The amount of fluid the patient should have is known; the amount of sodium chloride he should have is known; and his glucose balance can be maintained. Also by the administration of blood, plasma, and amino acids his protein balance can be maintained. We are often surprised to see how very well a patient will withstand a period of parenteral support for many days during surgical recovery.

7. *Resection and primary anastomosis* has been so successful in our hands, as well as in the hands of a great many others of greater experience, that we strongly advocate this procedure in any part of the colon except the rectum in all resectable patients who are not obstructed.

TABLE 6.—*Resection of Cancer of Rectum and Recto-Sigmoid, 1932-1946.*

	No. Cases	Percentage of Total Cases	No. Deaths	Percentage Mortality
Total	86			
Inoperable	30	34.9		
Palliative	8			
Resectable	56	65.1	5	8.9
Perineo-Abdominal	40		3*	7.5
Abdomino-Perineal	7		2	28.5
Kraske Procedure	4		0	0
Local Excision	5		0	0
Obstructed	12	13.9		

*There were 35 consecutive perineo-abdominal resections without a death. The thirty-sixth patient was 83 years of age and should have had a Kraske type of operation.

The resectioning and anastomosizing procedure as previously stated is becoming more popular. Wangensteen[13] reported 61 primary resections of the colon with 1 hospital death, a mortality of 1.6 per cent, which is remarkable. Not all of these were carcinomas. Meyer and associates[4] recently reported 20 cases of one stage resections and primary anastomosis of the left half of the colon with a mortality of 5 per cent. This report, which shows only cases of the left half of the colon, is an extreme test of feasibility of the one stage procedure. In Wangensteen's practice the "closed" type of anastomosis is used, while in Meyer's report "open" anastomosis is done.

We have a series (tables 4 and 5) of 33 resections using primary anastomosis with three deaths, a mortality of 9 per cent. This record is better than it appears if we are allowed to note the causes of these three deaths. One was in an insane woman who was extremely difficult to manage, particularly her gastric suction. Another died from leaking of a proximal enterostomy, which is one of the few cases in which a proximal enterostomy was used. The third was a poor technical anastomosis which was inexcusable.

The *scope of the resection* was extensive in a number of cases. In 5 patients sections of the small intestine, involved by extension of cancer, were removed. In 1 patient the greater curvature of the stomach, a section of the small intestine, and a section of the transverse colon were removed with primary closure. In another the uterus, ovaries, and tubes which were involved by extension from a recto-sigmoid cancer were removed with primary closure.

TYPES OF ANASTOMOSIS

Many different types of anastomosis are used and apparently all are successful in the hands of those who are advocating them. Reduction of the amount of soiling is a principle which cannot be ignored, and if this can be accomplished with the "closed" type of anastomosis while still securing a safe anastomosis, it should be preferable.

Many different methods of "closed" anastomosis are advocated and all of them have their good points. For a long time, both in the small and large intestine, we have practiced a modification of what is known as the "Kerr Operation"[6] with entire satisfaction. We do not know of a single instance in which this anastomosis has not been satisfactory in our hands and still it is extremely simple. It is illustrated by figure 3c, d, e, f.

RESECTION IN THE PRESENCE OF OBSTRUCTION

In the 184 cancers of the colon in this series, 34 patients, or 18 per cent, were received with intestinal obstruction. In the presence of obstruction or partial obstruction a more complicated problem confronts the surgeon. Obstruction does not necessarily mean a far advanced carcinoma. In fact, our experience has been that an obstructed patient is frequently a patient with a limited and localized carcinoma. It is generally admitted that in the presence of obstruction the treating of the obstruction independently of the carcinoma is advisable and we have until recently advocated this plan.

The "Miller-Abbott" tube is highly praised by many as a means of deflating a distended or obstructed bowel. It is quite troublesome to pass and we have not been able to accomplish results often enough to place confidence in it. To spend a number of hours in trying to pass the tube unsuccessfully is a loss of valuable time in a patient already in a serious condition.

Within the last few years we have been taking what may be considered greater chances with many obstructed patients and have done immediately one stage resections and anastomoses with remarkably good results. Unquestionably this is unwise if the distended bowel above the obstruction is not immediately relieved. While our experience is limited, we have in 5 patients within the last year resected the bowel, emptied the bowel above the obstruction, and then done a primary anastomosis with a satisfactory recovery in each case (fig. 3). We realize that this is quite unorthodox and unless care is taken, danger of soiling is present, but with great care we believe that the patient's chances frequently are just as good, or may be better, by a one stage resection and emptying of the proximal bowel, doing an anastomosis, and closing the abdomen. The restoration of the alimentary tract to its normal function is accomplished much more quickly in this manner than by a preliminary drainage of the bowel above the obstruction. A preliminary colostomy or enterostomy means a long period of waiting often with infection and contamination of the wound and frequently a further spreading of the cancer. It may be a greater hazard than the hazard of resecting and completing the operation in one stage.

In resections of the rectum and rectosigmoid with the restoration of the continuity of the bowel and preservation of the sphincter function, we are not able to speak with any experience except that gained many years ago when efforts were made to restore the rectum with the Kraske type of operation. This was abandoned after many trials as being unwise. It is more hazardous to the patient and less apt to result in a cure of the cancer, and therefore was abandoned for the more radical abdominal colostomy. Our practice in rectal cancer has been the perineo-abdominal resection reversing the Miles procedure. This in our hands has been extremely satisfactory and we see no reason to change it.[11]

SUMMARY

1. Late recognition of cancer of the colon is still the greatest obstacle to cure.

2. There is only one remedy available for treating cancer of the colon and that is surgery.

3. Extending the scope of operation has been accomplished in the past decade.

4. Reducing the number of operations has reduced the mortality as well as the period of disability.

5. These surgical advances have been possible because of

a. Preparation of the patient.

b. More anatomical abdominal incisions.

c. A proper regard for the circulation of the bowel.

d. Improved technique in anastomosis.

e. Putting the alimentary tract at rest by gastric suction until bowel healing is assured and peristalsis is restored.

f. Maintaining the patient's fluid, electrolytic, and nutritional balance until the period of alimentary tract rest is passed.

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ABSTRACT OF DISCUSSION

Dr. G. V. Brindley, Temple: Modern surgery of the colon has a relatively short history. This can be appreciated better when it is recalled that the first Mikulicz operation was performed only forty-three years ago. Remarkable progress has been made in the surgery of the colon since that time. This has been due to the keen interest and intensive study of this subject by such surgeons as Dr. Singleton and Dr. Kennedy. This paper today is another one of several valuable contributions Dr. Singleton and his associates have written upon the surgical management of lesions of the colon. A more optimistic point of view pertaining to carcinoma of the large intestine than has been held formerly is justified, for the cure of cancer here compares favorably with lesions of the breast, of the cervix, and probably is about three or four times as curable as is a malignant tumor of the stomach.

Certainly there is much in the paper worthy of commendation. Time will permit only a brief discussion of a few facts emphasized in this presentation. Some, but not enough, progress has been made in achieving an early diagnosis of these lesions. However, unquestionably more cases are diagnosed earlier than formerly as evidenced by the fact that more resectable lesions are being seen, and now not so infrequently the roentgenologist will report a growth that is relatively early in its development. Adequate preparation of the patient for surgery cannot be over emphasized. The reports in literature

and my own experience in the use of sulfa drugs leads me to the conclusion that these drugs are of distinct advantage in preparing the colon for a resection. Due consideration to the circulation of the intestine, the use of gastric suction postoperatively, and adequate supportive measures after surgery have been well emphasized. I congratulate the essayists that they have emphasized the fact that many more cases should be operated upon with resection of the lesion and primary anastomosis than has been true in the past. A majority of the carcinomas of the large intestine which have not produced or are accompanied by some mitigating complication are probably best resected by a one stage procedure. However, I do believe that it is well to stress that for a reasonable number of patients, multiple stage procedure still will be definitely safer. It is my conviction that the patient with an acute obstruction of the colon, the one with a perforated lesion and marked secondary infection or abscess, the patient with extensive fixation secondary to inflammatory changes, the patient with a fistula into an adjacent viscus, and also the old and markedly debilitated patients should be and are safer operated upon by multiple stage procedures.

Wangensteen wrote that the mortality for resection is more than doubled if performed when the bowel is acutely obstructed. Such a patient is in a poor physical state to undergo a major surgical operation because there is marked intestinal distention; the blood supply to the intestinal wall is impaired, the tissues are edematous and friable, there are ulcers of the mucosa, infection is present within the intestinal wall, and the lumen of the bowel is teeming with highly infectious bacteria predisposing to peritonitis. Because of the above facts, the proper healing of the anastomosis following a resection of an obstructed intestine will be doubtful. Furthermore, the patient with an obstruction is dehydrated and somewhat starved and has an altered chemical composition of the blood. When due concern is given to these facts, the hazard of a primary resection of an obstructed colon will be comprehended more fully. For such a patient it is urgent and the part of wisdom to do a first stage surgical decompression and later a resection of the neoplasm.

Dr. Singleton, closing: Dr. Brindley spoke from an extensive experience in colon surgery, giving advice pointing to conservatism which usually is best for the patient. All of us reluctantly give up a procedure in which we have confidence. It was maintained for a long time that drainage should always follow thyroidectomy and cholecystectomy. We have taught for years that resection and primary anastomoses of the left colon was against the rules. Progress in surgery is paved with changing good procedures for better ones. With increasing experience we are becoming more and more of the opinion that in many instances in the presence of an obstruction of the colon from cancer resection, emptying of the proximal bowel with a primary anastomosis is the safest procedure and therefore best for the patient.

ARMY MEDICAL DEPARTMENT BOARD

An Army Medical Department Board has been established at Brooke Army Medical Center, Fort Sam Houston, to study changes that will be required in Army medicine to keep abreast of concepts of modern warfare. Previously located at Carlisle Barracks, Carlisle, Pa., the board was discontinued during the war and its activities largely delegated to the field. The board will consider organization and equipment of medical units, tactical employment of Medical Department troops, and changes and improvements in Medical Department equipment.—S. G. O. Notes, July 31, 1946.

ESSENTIALS TO ADEQUATE GYNECOLOGIC PATIENT STUDY

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The effects of the global war upon civilian medical practice have reached into all specialties and are rapidly becoming more obvious. Gynecologists are liberally represented in the many thousands of physicians who have entered the armed forces. Consequently, many patients have been forced to consult non-specialists because of their pelvic symptoms. Some of these physicians or non-specialists are older men who under normal circumstances would have retired or had already retired but were literally drafted to continue or to resume practice and aid as much as possible in the care of civilian ill. Others have been practicing in specialties away from pelvic complaints. As such, these have drifted from old accepted principles of gynecologic patient study and further have not acquainted themselves with the few diagnostic aids which have been added since their earlier years in practice.

Another effect of the war has been produced directly upon the gynecologist, leaving him with more work than he can conveniently perform. Sometimes he has tried to compensate by circumventing the usual diagnostic aids, moving directly from office examination to major surgery. The motivating "hunch" or working diagnosis cannot always be accurate and sometimes leads him to a procedure which is not for the best interest of the patient's future health.

These reasons, as well as the belief that there is no short cut to adequate gynecologic patient study, form the incentive for this presentation. They suggest that it is high time physicians pause and review the basic principles of work-up in those patients with pelvic and lower abdominal complaints.

It appears that biopsy curettes are being utilized more and more for diagnostic procedures in cases of menorrhagia and metrorrhagia. This practice must be condemned with all possible vigor. The suction and the Randall types of curettes were devised for use in obtaining endometrial biopsies in those infertile or sterile women with normal or relatively normal menses, in order to prove or disprove the occurrence of ovulation. They were not intended for purposes of diagnostic curettage in cases of abnormal uterine bleeding.

From surgical pathological material, it has

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been determined that the average operator utilizing the ordinary curettes removes only 35 per cent of the uterine mucosa at the time of diagnostic curettage. It can therefore be seen that the average curettage would not infrequently miss an early adenocarcinoma of the corpus uteri. This failure suggests that the recovery of tissues from such lesions by the use of biopsy curettes is extremely inferior, in fact, low enough to make these new curettes worthless for such purposes. It must further be recalled that a high percentage of diagnostic curettages thoroughly done constitute good therapy, thus curing the disease temporarily or permanently and rendering unnecessary the use of large doses or varied preparations of the endocrines.

As stated above, the biopsy curette cannot be relied upon to remove the majority of endometrium. This is most certainly true when some arbitrary endpoint as a filled curette is used as the stopping point, which it is in some quarters. Another consideration which must not be overlooked is the patient's comfort. No matter how careful or gentle the operator, the biopsy curette is not painless. Physicians are therefore not justified in rasping the uterus of the unanesthetized woman to the point of producing syncope when one or two strips of endometrium produces ample material to ascertain whether ovulation has occurred. The so-called "fainting room" has no place in the office suite of the modern gynecologist. In this connection it must be admitted that hospitalization of all cases of menorrhagia or metrorrhagia for diagnostic curettage adds to the over-crowded condition of voluntary hospitals. There would seem to be no ready and acceptable substitute for this practice, in other words, no short cut for a well-done task.

Today, more than ever before, the physician moves directly from office examination to major gynecologic surgery. In most instances the end results are satisfactory. But take, for example, the patient with a myomatous uterus and abnormal uterine bleeding, especially in the form of metrorrhagia. It may be logical to assume that the bleeding is from a submucous myoma and that the only therapy required, therefore, is a supravaginal hysteromyomectomy. Such rapid cerebration and surgical action fails to take into account the fact that a myomatous uterus may, however small the incidence, be associated with such more serious pathological conditions as adenocarcinoma of the corpus, adenocarcinoma of the cervix, or even squamous cell carcinoma of the portio. With some of the latter complications, simple supravaginal hysteromyomectomy would be totally inadequate therapy in any language. The error would generally be detected by the pathologist, but at a time when the patient could no longer receive ideal therapy: that is, the chances for an acceptable salvage rate would have been utterly ruined.

It should hardly be necessary to mention squamous cell carcinoma of the cervix in the above connection. However, practically every report on cervical carcinomas includes disgraceful examples of poorly planned or ill-advised surgery. The most frequently recorded examples of this occur when a patient presents abnormal vaginal bleeding and the physician performs a hysterectomy, paying little or no attention to a history indicating the possibility of a cervix carcinoma, and in some instances without even so much as a preoperative vaginal examination. He may or may not, then, be surprised to learn that the vaginal bleeding persists after operation. The patient eventually falls into adequate channels, but not until the malignancy has been given ample opportunity to extend naturally or has been spread by the operation, so that full roentgen and radium irradiation is impossible because of the absent corpus. Such operations constitute carelessness or ignorance and cannot be condoned, even in times of an emergency in which civilian practice is hampered by manpower shortages, and further emphasize that all gynecologic symptoms and possibilities must be exhaustively investigated before the ultimate disposition of the case is arrived at.

In this connection, the taking of a careful and complete medical history, the performing of a thorough physical examination, and complete recording of each must be considered. These routines form the very basis of all branches of clinical medicine and one might be expected to apologize for even mentioning them, but the errors attributable to a failure to carry them out are legion. Moreover, circumventing as much of them as possible seems to be the common practice in a busy office. The above example relative to avoiding or failing to perform preoperative vaginal examinations is a notable one in this group. Another and less common error is found in connection with extra-uterine pelvic masses with no gynecologic complaints save for pelvic discomfort or pain. At operation a sigmoid diverticulitis may be discovered. The operator then recalls that he failed to perform a rectal examination and that the patient tried to present intestinal complaints. He realizes that a roentgenologist utilizing a simple barium enema might well have aided in the diagnosis by discovering diverticulosis, but his chagrin cannot be minimized.

The most embarrassing sequel of inadequate patient study in this group falls among those women still in the childbearing years. A lower abdominal midline mass arising out of the pelvis is discovered. The patient may or may not admit a period of amenorrhea but she stoutly denies the possibility of a pregnancy. An exploratory laparotomy is done and to the embarrassment of the operator the uterus appears to contain a pregnancy. In this predicament there is no differential diagnostic aid available to him without endangering the continuation of the pregnancy, if, indeed, one actually exists. There is little recourse except to close the abdomen after having accomplished literally nothing. If an acceptable pregnancy test is positive and/or a roentgenogram presents fetal bones, the patient may not have suffered much by this hasty procedure and the pregnancy may proceed to term uneventfully or be later expelled as a missed abortion. However, if all tests, which should have been performed preoperatively, prove to be negative and a degenerating intramural myoma simulating an intra-uterine pregnancy exists, the predicament necessitating re-operation leaves little room for the physician to save face. The old rule relative to a uterine tumor in a woman during the childbearing years being a pregnancy until proven otherwise is still an excellent one. Moreover, nothing should be spared by way of adequate patient study in order to arrive at an accurate preoperative differential diagnosis from intra- or extra-uterine pregnancy.

Specialists limiting their practice to definite organs or systems are prone to ignore adjacent ones and to think only in terms of their narrow fields. The gynecologist must be included in this category. Diverticulitis, discussed above, is an infrequent extra-genital complication confused with genital lesions—infrequent only because of the relatively low incidence of diverticulitis.

The following case recently seen typifies a more common source of error in differential diagnosis in pelvic and lower abdominal complaints.

The patient presented an infertility problem in that she had previously had a late abortion after which she had been unable to conceive. She now presented a colicky pain localized to the right lower abdominal quadrant and pelvis. She had had an appendectomy in late childhood. The pain was unrelated to the menstrual cycle, was constant, but was accentuated at times to the point of partial incapacitation. Her physician could find no pelvic pathologic lesion except for retroversion of the uterus. A round ligament suspension was performed promptly and there followed no alteration whatsoever in any phase of the chief complaint. The patient was then subjected to a prolonged series of expensive intramuscular "shots," again with no effect upon the pain. In disgust she discontinued therapy and attempted to persuade herself that she was neurotic. She failed in this but refused to consult a physician again until a few years later when the same pain became more severe. Normal pelvic organs were found, but there was moderate tenderness on vaginal palpation of the pelvic portion of the right ureter, which pain was similar to that complained of. Less tenderness was found along the course of the upper ureter on abdominal palpation. She was referred to a urologist who confirmed the diagnosis of a ureteral stricture. The patient is still under early treatment for ureteral dilatation, but that she will be made more comfortable, if not cured, is a certainty, for some relief followed the first dilatation in which a relatively small catheter was employed. Ultimate improvement or cure will be her lot, but consider the years of pain she suffered, the major gynecologic surgery to suspend an asymptomatic retroversion, and the endocrines given blindly, all because her gynecologist could not project his thoughts beyond the realm of her internal genitalia.

These two examples amply emphasize the fact that not all pathology located within the bounds of the bony pelvis belongs in the field of strict gynecology. These reminders to the gynecologist tell him that he must be on the alert for the possibility of extra-genital pathology even though it is not grossly palpable and even in the face of presumed genital pathology such as uterine displacement, which need not be abnormal in the strict sense of the word.

One of the simplest and most gratifying diagnostic aids in adequate gynecologic work-up is the pessary designed to maintain a displaced uterus in good anterior position after manual replacement. In spite of this well established fact, its use is too frequently ignored and, instead, certain physicians subject every patient with malposition of the uterus immediately to a suspension operation if she can be persuaded to submit to it. It must be recalled that a good many women have asymptomatic uterine retrodisplacements. The term asymptomatic here applies not only to freedom from pain and abnormal uterine bleeding but also to little or no interference with conception. To recommend routine operation prior to manual replacement with an adequate trial use of a properly fitting pessary constitutes incomplete patient work-up. It probably means one of several things, *furor operandi,* misplaced desire for worldly gain, or ignorance of the pessary test.

In recent years, conscientious clinicians and similar pathologists have become alarmed over the relatively high incidence of failures in making, from curettings, a pathological diagnosis which would explain the cause of menorrhagia or metrorrhagia. It must be admitted that the diagnosis of type of endometrium does not constitute an explanation of the cause of abnormal uterine bleeding. These same investigators have re-

duced the incidence of inadequate diagnosis by more careful attention to the type of endometrium with respect to the phase of the cycle and by more careful timing of the diagnostic curettage. For example, the curettage must be done during the bleeding phase and not after an endometrial polyp has had time to be sloughed off or hyperplasia an opportunity to heal itself. Similarly, the diagnosis of irregular shedding of the endometrium in any of its forms is possible only when the material is obtained at a time in the menstrual cycle when normal endometrium would have been shed or regenerated.

In still another way the clinician can be of inestimable help to the pathologist and therefore also to the patient. Especially in women in advancing years or where the possibility of a uterine malignancy is increased, the curettage should be fractional: that is, the cervical canal should first be thoroughly curetted and this specimen submitted separate from that obtained from the body of the uterus. In the event, for example, of an adenocarcinoma, its location is readily fixed, even though the tissue itself is not strictly characteristic of either endometrium or cervical canal.

The gynecologist frequently has need of consultation with the urologist. Actually, some training in female urology, even though the course may not be protracted, is quite as essential to the pure gynecologist as is some obstetric experience. If the pelvic or lower abdominal symptoms are not clearly referable to the urinary tract, the patient will invariably seek the advice of a gynecologist. He must be conscious of certain urological conditions which confuse the issue and he must seek the aid of a urologist, unless, of course, he also practices female urology. One case history of this kind has already been cited.

Another very important time when the urologist can be of great aid is when the patient complains of stress incontinence. It is our belief that all these patients should be subjected to cystoscopy before pelvic surgery is planned. If relaxation of the vesicle sphincter is found, as it often is following childbirth injuries, plication of the sphincter is not only in order but also can be expected to afford complete relief in about 80 per cent of the cases. If such relaxation of the vesicle sphincter cannot be demonstrated, it is doubtful whether one is justified in performing a plication procedure. If he does, nevertheless, undertake it, he must be prepared to accept a high percentage of failures or must warn the patient in advance that the procedure may not afford relief. Experience has demonstrated these failures in the absence of vesicle sphincter relaxation and has suggested a neurogenic basis for the stress incontinence even though no spina bifida or other obvious cord lesion is demonstrated.

A fair number of patients with stress incontinence and no vesicle sphincter relaxation will be found to have urethritis or trigonitis. These women can be treated medically or with topical applications, and major surgery is neither indicated nor can it afford relief of symptoms.

The urologist can supply much information in cases of suspected or proven vesicovaginal fistula. In the event of the latter, he can locate the false passage with respect to the ureteral and urethral orifices. In the event of a suspected fistula, he can often supply confirmatory evidence of its presence or absence. A recent case of this kind was particularly illuminating.

The patient had had a large vesicovaginal fistula following a difficult obstetrical delivery per vaginam. She had had two subsequent operations for closure of the fistula. She claimed no permanent cure from either, though it was thought that the amount of urine drained through the vagina after the second closure was less than before. Moreover, she did void in small amounts and the fistula was believed to function primarily when she was in the dorsal recumbent position. At examination the scarred area in the anterior vaginal wall was easily located. There was a small amount of urine in the vagina, but no urine could be seen coming from the suspected area even in the knee-chest position and even after the injection of methylene blue; neither could a fistula be probed in this area. She was referred to a urologist who found no intra-vesicle evidence of a fistula but considerable granular urethritis. It was postulated that she was incontinent from the urethritis, the urine entering the vagina when she lay on her back and later draining therefrom when she arose. The urethra was treated, prompt cure was effected, and an unnecessary operative procedure was averted.

Purposely little has been said of low back pain and of rectal pathology. The former has frequently been discussed, for there is no region of the female body which attracts the attention of a greater variety of specialists. The lower back has been described as the battle ground of orthopedist, neurologist, gynecologist, urologist, proctologist, and internist. Hemorrhoids, anal fissures, and other rectal lesions come to the attention of the gynecologist with or without gynecologic pathology, and the correction of these often frees the woman of pelvic complaints.

There is one small group of women which should come in for greater consideration. Obstetric practice has improved to the point where good anatomical end results are the rule rather than the exception. Consequently, the modern obstetrician can frequently point out with pride that the patient

must feel very well indeed since the anatomical result is excellent. This pride is occasionally injured when the patient counters that she feels as though everything would fall out after she has been up and about for only a part of the day. There is no ready diagnostic aid in these instances and one generally assumes from the presence of varicosities elsewhere that varicosities are present in the broad ligaments to account for the symptomatology.

Finally, but not necessarily of least value, are some roentgenologic aids to adequate patient study in gynecology. Though the preoperative diagnosis of the exact nature of an adnexal tumor may not be as important as the gross diagnosis at operation and may primarily be of academic preoperative interest, there is at least one pure gynecologic tumor which may be visualized on a roentgenogram. This is the dermoid cyst of the ovary which may cast a shadow in the absence of osseous tissue and teeth, the sebacious material being more radio-opaque than ordinary soft tissue.

The roentenogram may be of value in certain cases of sterility or infertility. Similarly, other diagnostic aids are limited to this narrow field of gynecology. As such, they are not included here.

Intravenous or retrograde pyelo-ureterography is a roentgen aid of much value prior to institution of roentgen irradiation in cases of squamous cell carcinoma of the cervix which have advanced to or beyond League of Nations Stage III. In these the lower end of the ureter may be surrounded or partially obstructed by new growth, and the swelling of such tissues following early therapy will then almost certainly afford greater obstruction with an excellent opportunity for the development of complete urinary tract obstruction. He who is forewarned of this possibility will afford freer drainage of urine before the life of the patient is endangered.

SUMMARY AND CONCLUSIONS

In summary, the importance, to the patient and to good gynecologic practice, of adequate or complete patient study has been emphasized. The more common diagnostic aids have been reviewed and special problems have been omitted. There appear to be no short cuts, no means of circumventing thorough work-up of gynecologic cases without running the risk of missing the diagnosis and performing inadequate therapy or unnecessary surgery for the true condition and thereby endangering the immediate or the remote health of the woman with pelvic symptoms.

1. Undesired effects of the war upon gynecologic practice are enumerated.
2. The biopsy curette cannot replace the ordinary curette in cases of abnormal uterine bleeding for purposes of either diagnosis or treatment.
3. Diagnostic curettage should be done in cases of abnormal uterine bleeding even in the face of an obvious and non-malignant cause of the bleeding.
4. All pelvic complaints should be exhaustively investigated before surgical treatment is planned.
5. There is no substitute for complete medical history taking and thorough general and regional physical examination.
6. The gynecologist must be conscious of extra-genital pelvic pathology even in the presence of presumed genital pathology.
7. The pessary test is still applicable to determine whether malposition of the uterus is actually the cause of pelvic symptoms.
8. Diagnostic curettage must be performed at the optimal time for recovery of pathological endometrium.
9. Fractional curettage should be done in order to aid in localizing the lesion.
10. The urologist, the proctologist, the orthopedist, the neurologist, and the roentgenologist should be liberally consulted.

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ABSTRACT OF DISCUSSION

Dr. Karl John Karnaky, Houston: I enjoyed Dr. Dippel's paper very much. I would like to discuss this because I am particularly interested in office gynecology and will soon publish a book on this subject. In this book I have reviewed probably 4,000 biopsies. The pain from a Randall curette is very great. A lot of endometrium can be secured by pressure on the uterus during biopsy. As far as its being an adequate examination, I have found adenocarcinoma this way many times. I find endometriosis this way and can determine at examination by this method the difference between a good and a bad doctor. I make similar examinations for gonorrhea using biopsy specimens from the urethra, vagina, and cervix, and I found many cases this way during the war. Of course, one should always look for trichomonas early; Monilia especially. This is always important. The patient should keep a record of her menstrual history, it is so helpful in abortions as well as in meno-metrorrhagia. Many patients with intermenstrual bleeding are sent to me. While a dilatation and curettage does cure most menstrual irregularities, 10 per cent only of all gynecologic patients need operative procedure. Many have had to be operated on once or twice, whereas hormones could have cured them immediately. I did 884 biopsies for ectrophion last year. Once in a while I find an epidermoid of the cervix. If it is diagnosed early, it is a help. It also helps to tell whether a woman ovulates or not.

Dr. Dippel (closing): My argument about admitting all patients for dilatation and curettage is not only for diagnostic purposes, although it is for this largely. Early cancer can be found with biopsy. Many women have irregularities of the endometrium. Hospitalization for this, in order to perform a diagnostic dilatation and curettage is justified. Any procedure short of this is incomplete. Except by micro-

scopic examination of endometrium obtained at the proper time of the cycle, one cannot ascertain the cause of either menorrhagia or metrorrhagia and, therefore, will not be able to decide the proper hormone therapy to use.

THE USE OF THIOURACIL IN THE TREATMENT OF THYROTOXICOSIS

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Following the re-introduction of the use of iodine by Plummer in 1923 there was a marked lowering of the operative mortality in patients with exophthalmic goiter. The position of sedation and bed rest had already been established. The only new advances from then until 1942 were the adequate recognition and correction of the nutritional deficiencies that are a part of the disorder and improvements in the operative technique. Practically all authorities agree that Graves' disease is a metabolic disorder affecting the autonomic nervous system as well as the thyroid gland and that surgical ablation is but an attack upon an end organ and not upon the etiologic cause of the disease. Nevertheless iodine preparation followed by thyroidectomy has become the procedure of choice for economic reasons and more importantly because no more specific therapy was available—this despite the fact that the recurrence rate ranges between 10 and 15 per cent.

In 1941 the MacKenzies and McCollum[13] reported that rats fed sulfaguanidine for a period of weeks developed marked thyroid hyperplasia. Richter and Clisby[16] made a similar observation while studying the chronic toxicity of phenylthiourea. Kennedy,[11] in England, working on the goitrogenic properties of rapeseed suggested that the active principle might be a thiourea derivative and tested allylthiourea and later thiourea. He found that prolonged oral administration in rats resulted in hypertrophy of the gland; that the sulfaguanidine effect was not produced by sulfanilic acid or guanidine but by a group of sulfonamides and by thiourea. These experiments thus formed the basis for the experimental use of a new series of chemical agents possessing potent goitrogenic action. Astwood[3] studied 106 of these chemical agents and found that thiourea and 2-thiouracil were the most effective goitrogens of the group and confirmed the MacKenzies'[12] finding that, unlike goitrogens of the thiocyanate group, the hyperplastic effect was not abolished by iodine and that there was a depression of the basal rate of oxygen consumption.

Astwood[1] was the first to utilize these agents in human patients with hyperthyroidism. He reported 6 successfully treated patients utilizing thiourea in 1943. Himsworth[9] shortly thereafter confirmed Astwood's observations on thiourea in 8 patients. With the discovery that thiouracil was the more effective of the two agents, thiourea was supplanted. The first large series utilizing thiouracil was that of Robert Williams.[18] Since that time the records of more than 1,100 thiouracil treated cases of thyrotoxicosis have appeared in the literature. It was our original intention to report our experience with the use of thiouracil in treating some 45 patients. This is such a small number in terms of the literature already available that we decided instead to evaluate the present status of thiouracil in the treatment of thyrotoxicosis comparing our cases with the experiences noted in a review of the literature. Most of our patients were prepared with thiouracil for surgical thyroidectomy, only a few of them receiving thiouracil alone on a prolonged basis.

It is not our intention to review here the symptoms and signs or the laboratory evidence necessary for the diagnosis of hyperthyroidism. The patients studied were all examples of classic Graves' disease with exophthalmos and diffuse enlargement of the thyroid or of nodular enlargement of the thyroid with thyrotoxicosis. Some merited the additional appellation of being thyrocardiacs and we have studied a few patients with coronary heart disease and normal thyroids to whom thiouracil was administered. No patients with nontoxic goiter were studied.

ROUTINE OF THERAPY

Thiouracil is a chemical very similar to a normal constituent of the body, uracil, with a sulfur replacing oxygen in the formula. It is readily absorbed from the gastro-intestinal tract and is excreted rapidly in the urine. It appears in all of the body tissues thus far studied, in especially high concentration in the red blood cells. Although not a protein, it attaches itself to proteins, particularly those in red cells. Because of the rapid excretion it is necessary to give it at frequent intervals during a twenty-four hour period. According to the dosage utilized per day, thiouracil is usually administered at four, six, eight, or perhaps twelve hour intervals during the waking hours. When necessary to discontinue the administration, thiouracil ordinarily disappears from the body within forty-eight to seventy-two hours. Although the first case reports advocated relatively

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high dosage during the initial period of therapy, even up to 1.6 and 2 Gm. per day, it soon became apparent that such doses were accompanied by toxic symptoms and the dosage was reduced. By the time it was possible to obtain adequate quantities of the drug,* toxicity reactions were in the literature. Hence we started with 0.6 Gm. and 0.8 Gm. as our daily "ceiling" dose. Various dosage schedules have been utilized in individual cases but the consensus now is to begin with 0.6 Gm. per day. This is usually given 0.1 Gm. every three hours until 0.6 Gm. are given or, more commonly, 0.2 Gm. every six hours during the daytime. When the clinical state of the patient improves and the metabolism falls a perceptible amount, the dose is reduced to 0.4 Gm. daily and when the basal rate and pulse rate, as well as other clinical indices indicate that the patient has reached normality, maintenance dosage of 0.1 Gm. or 0.2 Gm. daily is begun. Should the metabolic rate increase, the dose is raised to 0.3 or 0.4 Gm. again as needed Patients were hospitalized for only two or three days during the period of diagnosis. Otherwise they were treated as ambulatory patients. Originally they were seen once a week for the first three or four weeks, then at two-week intervals. In view of the most recent data on toxic reactions produced by thiouracil, it has been our plan to see them weekly until operation or at least until three months have passed. At each visit a leukocyte count and differential is done as well as a physical examination and a basal metabolic determination as indicated. The patients were asked to rest one to two hours in the afternoon and evening and to forego any unusual physical exertion but otherwise were not restricted. They were placed on a 3,000 to 4,000 calorie diet and given additional vitamins, C and the full B complex, to be taken daily.

As indicated above, most of our patients were prepared for operation and, accordingly, iodine was given at some time during the preparation. At first no iodine was utilized. The increase in vascularity and friability of the gland caused the various surgeons to change tactics The reports of Williams and Clute[19] and of Bartels[6] suggested that iodine be offered in conjunction with thiouracil during the last ten days prior to operation. This has been our routine although at times we have deviated by giving iodine almost from the inception of therapy. In such cases our course was dictated by the fact that thiouracil produced sufficient hyperplasia of the thyroid gland to cause a demonstrable enlargement which was uncomfortable to the patient. At times, bruits, previously absent, made their appearance—another indication of the increased vascularity. It is not meant to imply that the appearance of a bruit over the thyroid gland justifies the exhibition of iodine but the presence of pressure symptoms due to an enlarged thyroid does. When iodine was used in conjunction, 5 minims of the saturated solution of potassium iodide were given four times daily in ice cold milk. It should be noted that Williams has pointed out that Lugol's solution interacts with thiouracil in vitro. Hence, it is wise not to give this soluton within one hour after the administration of thiouracil. There has been no note of the interaction of the saturated solution or of the syrup of hydriotic acid with thiouracil. Finally, for completeness, it should be pointed out that Williams, who undoubtedly has had the most extensive experience with thiouracil, recommends that iodine be given throughout the period of thiouracil exhibition.[17] This has not been necessary as a routine practice in our experience.

RESULTS OF THERAPY

How long should such therapy be continued? The answer depends upon what program one has embarked. If one is trying but to prepare the patient for thyroidectomy, thiouracil is continued until the patient is metabolically normal and clinically free of all symptoms and signs of hyperthyroidism. This occurs at different times with various patients but in our experience averages from five to six weeks. Patients usually state they feel much improved at the end of seven to fourteen days, but the pulse rate and basal metabolic rate as well as the circulation time and blood cholesterol concentration have usually not returned to normal for three to six weeks. Naturally the dosage of thiouracil, the preceding therapy, the severity of the disease, and the degree of emotional stress will influence the time of response. Ordinarily, if iodine has been given in the preceding one to two months, if the goiter is a nodular one, or if the patient is normal, the response will be delayed. If the patient has been on iodine just prior to thiouracil exhibition and then the iodine has been removed, not only is the response delayed but often the basal metabolic rate and the toxicity increase for a short time. Postoperatively it is not necessary to give iodine or thiouracil unless insufficient tissue has been removed or a recurrence develops. We believe that with the exception of those cases wherein thiouracil was discontinued because of a toxic reaction, the metabolic response has been almost universal. Early in our studies we gave insufficient quantities of the drug and expected a response too early (2 cases) and as a result we discontinued the drug and classified the

*We wish to thank Mr. K. M. Smoot of the Winthrop Chemical Co., Inc., for providing us with ample supplies of thiouracil.

cases as failures. In the light of further experience, we believe that these cases would have responded had we carried on. More importantly, the basal metabolic rate which averaged about + 45 per cent in our collected series, fell to a range between —10 and + 5 per cent at the time selected for operation. Furthermore, continued observation showed that such levels were "bottom" levels, unmoved by further iodine therapy. Thus, patients are now presented to the surgeon at no further risk than were he operating on a nontoxic thyroid, say, for cosmetic reasons.

As a corollary of this, we have seen no instances of preoperative or postoperative thyroid storm or crisis since we have utilized a thiouracil preparation. In our opinion, thiouracil is by far the best agent thus far made available for preparing patients for surgical thyroidectomy. Authoritative opinion throughout the country is in agreement with this conclusion.

For the second part of the problem, the conclusions are less dogmatic. What is the value of thiouracil in controlling hyperthyroidism without the addition of surgical ablation? Sufficient time has not elapsed to present a final opinion. Thiouracil has been available slightly less than three years and only in several large series, such as those of Williams,[17] of Astwood,[2] and of Barr and Shorr,[5] are there sufficient follow-up periods to catalogue results. Our own experience is almost nil on this phase of the problem. From the literature these tentative conclusions may be stated: The maintenance dose ranges from 50 mg. to 200 mg. daily. Relapses may occur at any time but are particularly prone to occur if the therapy has been carried on continuously for less than nine to twelve months. The latter period is recommended. The response to second and even third courses is described as good, but the incidence of toxic reactions rises with the length of therapy. Furthermore, since the serious toxic reactions are probably hypersensitivity reactions, intermittency lends itself to an increase of such reactions. Thus in prolonged therapy it is wiser to keep the therapy continuous even if in small doses, for example, 100 mg. every other day. Since thiouracil is goitrogenic, greater degrees of hyperplasia of the glandular tissue may occur. Of course, this can be counteracted when necessary by the additional use of dessicated thyroid in 60 to 96 mg. doses but such constant daily medication is troublesome. The necessity of juggling the dose to keep from producing clinical myxedema is also bothersome. In the final analysis, however, it is the incidence of toxic reactions that is the most potent argument against prolonged therapy, for the longer the therapy the greater the possibility of such reactions. In all fairness it should be stated that there are now several large series of successfully controlled cases, well over 300, in the literature.

TOXIC REACTIONS

As stated above, our series has been singularly free of any serious toxic reactions. There have been only maculopapular rashes (3 cases), edema of the feet (1), leukopenia (3), and one instance of stomatitis possibly due to thiouracil. None of our patients has exhibited agranulocytosis, jaundice, or other hematologic aberrations. One patient died suddenly and will be reported at greater length. Whether this death was due to thiouracil is very questionable and since no autopsy was performed, there must be a question of doubt, especially since a similar case has been reported by Barr and Shorr[5] and since Marine[14] reported myocardial changes in some animals experimentally given thiouracil. There have been four extensive reports on toxic reactions to thiouracil and of these the collected series of Moore[15] is the most valid up to April, 1945, and that of Williams[20] the most comprehensive, carrying the data through August, 1945. The latter report appeared in the January, 1946, issue of the *Journal of Clinical Endocrinology*, made available March 25, 1946. The following symptoms and signs have been reported: headache, nausea and vomiting, diarrhea, jaundice, hematuria, leukopenia, agranulocytosis, purpura, fever, urticaria, maculopapular rash, arthritis, enlargement of the lymph nodes, enlargement of the submaxillary salivary glands, oral sepsis, psychosis, and edema of the feet. Many of these were poorly, if at all, related to the exhibition of the drug, yet are included. In certain of the toxic reactions, such as edema of the feet and some instances of leukopenia, the dosage of thiouracil was excessive, over 1 Gm. daily. In the light of later experience, such doses are not necessary and these evidences of toxicity do not appear in later case reports. The only toxic properties of any frequency are leukopenia, agranulocytosis, skin rashes, and febrile reactions or "drug fever."

Drug fever occurs in from 3 to 5 per cent of the patients treated. It usually occurs between the seventh and the eleventh day, occasionally at other times up to the fourth week. The degree of fever is usually mild and lasts but one to two days after cessation of the drug. It may recur on restarting therapy and should this happen it usually appears within six to twenty-four hours.

Skin rashes are not frequent and usually

disappear with reduction of the daily dose for a few days; if not, the drug may need to be discontinued. The rash may or may not recur with restarting the drug.

The incidence of all toxic reactions is about 12 per cent. Drug fevers account roughly for 5 per cent, miscellaneous reactions account for about 2 per cent, and the remaining 5 per cent accounted for by leukopenia (3.4 per cent) and agranulocytosis (1.8 per cent).

Of the greatest concern are these latter manifestations, leukopenia and agranulocytosis. Of the group of agranulocytosis, 19 case reports have appeared in the literature and of these 5 patients died, a mortality of 26 per cent. It is notable that in both extensive reviews it is pointed out that agranulocytosis occurred between the fourth and eighth week of thiouracil therapy. Unfortunately, there appeared to be no exact quantitative relationship between the total dose of thiouracil and the onset of agranulocytosis since the dosage in the various case reports varied from 4.2 Gm. to 65.2 Gm. Four of the 19 patients had had thiouracil therapy previously without toxic reaction.

Leukopenia, that is, a leukocyte count of 3,000 or less, occurred in about 3 per cent of the case reports. This unfortunately did not always precede agranulocytosis with sufficient time interval to allow recognition of the impending danger even in well studied patients. Unfortunately, also, hyperthyroidism per se is accompanied in many instances by a relative leukopenia and lymphocytosis so that control counts and differential studies are a requisite in each patient before starting therapy. In addition the situation is beclouded further by the statement of Himsworth[10] that the Arneth count swings to the left in all cases treated with thiouracil. He feels the degree of shift is related to the daily dosage, that 0.8 Gm. daily will universally depress the leukocyte count. Since this dose is no longer utilized except in rare instances, the danger seems slight. Obviously, when the count falls to 3,500 or below or the neutrophile count falls to 25 per cent or lower, thiouracil should be discontinued. For agranulocytosis, thiouracil is immediately discontinued and penicillin is offered. The nursing care and nutritional status of the patient are watched carefully. Many other agents have been recommended, including crude liver extract orally and intramuscularly and especially the L. casei factor. None can be said to be specific or even suggestively helpful.

In summary, toxic reactions occur in approximately 12 per cent of patients receiving thiouracil. Most of the reactions are mild, of no serious significance, and need not cause discontinuance of therapy. The most serious reaction, agranulocytosis, has occurred in approximately 2 per cent of patients and has led to 5 deaths in about 1,100 cases. Unfortunately it may occur at any time without adequate warning but usually occurs between the fourth and eighth week. Leukopenia, possibly a forerunner, also occurs between the fourth and sixth week. These facts make it imperative to watch all patients extremely carefully, and to caution all patients to report any unusual lassitude, malaise, febrile reaction, sore throat, or infection as soon as it occurs and to report for a physical and hematologic check-up whether they have been seen but several days previously or not.

MECHANISM OF ACTION

Although there has been a great deal of theorizing regarding the mechanism of action of thiouracil, a completely acceptable thesis has not yet appeared. Astwood and the MacKenzies originally proposed that the effects observed were due to an interference with the production of thyroid hormone. Sufficient data are now available to reveal that the hyperplastic reaction produced in the thyroid gland is not due to direct effect upon the gland but due to stimulation from the pituitary, presumably by means of the thyrotropic hormone. As yet no increased amounts of thyrotropic hormone have been demonstrated in the blood. This failure to demonstrate an increase is explained away as being due to increased utilization of the thyrotropic hormone by the hyperplastic tissue. The fact that the effects of thiouracil can be circumvented by thyroxin led to the conclusion that thiouracil does not act by inhibiting the effect of thyroxin on the end organs or cells of the body. On the basis of these partial experiments, then, our current concept has developed: that thiouracil interferes with the synthesis of thyroid hormone in the thyroid gland. As the available hormone gradually diminishes, the anterior pituitary gland is activated to elaborate more thyrotropic hormone. The thyrotropic hormone produces ineffectual hyperplasia of the acinar tissue of the thyroid. This effect in the intact animal is functionally similar to that seen after surgical ablation of the thyroid.

Finally, there are investigations to determine the mechanism by which the synthesis of thyroid hormone is prevented. Franklin and Chaikoff,[8] utilizing surviving thyroid slices, demonstrated that sulfanilamide inhibited the conversion of iodine to diiodotyrosine and thyroxin. Baumann, Metzger, and Marine[7] reported that in animals treated with thiourea there was a rapid loss of both thyroxin and nonthyroxin iodine from the

thyroid. These findings were confirmed in tracer studies with radioactive iodine. The feeding of thiouracil also interfered with the incorporation of injected radioactive iodine into diiodotyrosine and thyroxin. Some work has been done on the mode of interference with iodinization and to date the best assumptions are those based upon interference of thiouracil with the cytochrome-cytochrome oxidase system involved in the formation of diiodotyrosine and thyroxin by the thyroid gland by inhibition of peroxidase.

EVALUATION

We believe the above data testify strongly to the present importance of thiouracil in the treatment of thyrotoxicosis. In our experience and also from the literature, thiouracil is by far the best medication for the preparation of the patient for surgical ablation. We believe that iodine serves only as an auxiliary drug and one to "fall back upon" when thiouracil toxic reactions appear. For this reason it appears that every internist should be familiar with this preparation and should be aware of its effects as well as of its toxic side effects.

Our position regarding the value of thiouracil in the prolonged treatment of thyrotoxicosis is less dogmatic. Whereas originally we believed it was the treatment of choice supplanting surgical ablation, as months passed by and toxicity reports increased, we became more hesitant. If the incidence of significant toxic reactions were truly 12 per cent, we should be forced to drop this phase of thiouracil usage in all except patients refusing operation, those patients intolerant of iodine, and those patients impossible to prepare for surgical ablation otherwise. But actually the 12 per cent figure represents a composite figure of all toxic reactions, 80 per cent of which are extremely minor and of no significance. The other 20 per cent, however, represents the patients developing agranulocytosis and in view of the present poor therapy for agranulocytosis, this is a very serious handicap. This, then, was our viewpoint until December, 1945, at which time Astwood and VanderLoan[4] reported their experience with two new derivatives of thiouracil, namely, 6-ethyl thiouracil and 6-n-propyl thiouracil. They found these compounds to be ten times as active as thiouracil when tested in rats, as well as having a longer effect following single doses.

They next tested these two agents in patients with thyrotoxicosis, utilizing the ethyl derivative in 14 patients. Because of the difficulty in synthesizing this derivative, they soon shifted to the propyl derivative. They believe that this derivative is five times as active as thiouracil and is definitely superior to thiouracil in terms of lasting effect. Most important is that in terms of the small dose needed, no toxic reactions were noted. Indeed, some patients who previously exhibited poor tolerance for thiouracil could be shifted to 6-n propyl thiouracil with no side effects, even in 4 patients shown to possess a strong tendency to allergic sensitivity. 6-n-Propyl thiouracil is available in 25 mg. tablets. The usual dosage initially is from 50 to 75 mg. daily, given as 25 mg. orally at intervals of eight hours. The maintenance dose has been found to be between 25 and 50 mg. daily.

We have not used propyl thiouracil, but if this agent bears out the original report, we may yet look forward to what has been sought for many years, a so-called medical thyroidectomy without mortality. It should be emphasized that even this wish is not the final goal in defeating thyrotoxicosis, for the etiologic cause certainly does not rest in the thyroid nor in the effects of thyroid hormone.

CONCLUSIONS

1. In our experience, thiouracil is the medication of choice for the preoperative management of patients with thyrotoxicosis.

2. At the present time, because of the occurrence of agranulocytosis reported in the literature, we cannot recommend thiouracil therapy for routine prolonged medical management of thyrotoxic patients.

3. The preliminary reports of the activity of newer thiouracil derivatives, particularly propyl thiouracil, suggest that the toxic reactions may be less and that this agent or newer derivatives will be satisfactory for prolonged medical management.

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Medical Arts Bldg.

ABSTRACT OF DISCUSSION

Dr. Raymond Gregory, Galveston: The authors are commended for their presentation of the essential information concerning the use of thiouracil in hyperthyroidism. I am glad to see them place the proper emphasis on the toxicity.

We have observed the effects of this substance in a number of patients in the John Sealy Hospital during the past two or three years. All of our patients have been hospitalized. While we have observed the dramatically good results in some patients, we are not as enthusiastic about the use of thiouracil as the authors of this paper. This is partly due to the fact that most of our charity and private patients come from some distance and from other physicians and have been subjected to previous iodine therapy. Our experience in this type of patient confirms the notoriously poor results obtained from thiouracil by almost everyone. In a number of such cases there has been no improvement in the metabolic state. It is in this type that the serious toxic reactions are most prone to occur because of the tendency to continue the use of full dosage over too many weeks in the hope of success. Our experience with thiouracil in patients who have taken iodine for long periods has been so poor that we are at present discouraging its use in these cases.

We emphasize the idea that thiouracil and related substances are but another type of symptomatic treatment which is best directed at the preoperative preparation of the hyperthyroid patient. It does not represent a specific physiologic attack on the cause of the disease.

Thiouracil is superior to iodine for the following reasons:

1. It is more potent in controlling the hyperthyroidism.

2. It will reduce the excessive metabolic state to normal levels in a high percentage of properly selected cases. Iodine will seldom do this.

3. So far as I know, there is no recurrence of the hyperthyroidism under adequate thiouracil therapy. This usually occurs with long continued iodine therapy.

We have noted the usual types of toxic effects. There has been one near fatality from agranulocytosis, sepsis, and severe liver damage. Death was fortunately averted by penicillin. All of the other agents were also employed.

There has been one case of congestive cardiac failure in a young woman during thiouracil therapy. We believe this was due to toxic effects of the drug on the myocardium rather than thyrotoxicosis because the degree of hyperthyroidism was well under control before the failure resulted.

This same patient developed the only case of postoperative "thyroid storm" which we have observed in patients prepared with thiouracil.

We hesitate to recommend the general and widespread use of this substance because we fear that the toxic effects are not too likely to be properly controlled.

We have had no experience with the ethyl or propyl derivatives. If their reported greater potency and diminished toxicity is generally confirmed thiouracil should be immediately supplanted.

Dr. Arthur Grollman, Dallas: The authors have summarized very fully the present status of thiouracil in the treatment of thyrotoxicosis. As pointed out several years ago* thiouracil has a definite usefulness (1) as a preoperative measure particularly in cases of thyrotoxicosis due to toxic adenoma, (2) when combined with irradiation in the treatment of certain selected cases of Graves' disease, and (3) as a therapeutic test in the diagnosis of certain cases of masked hyperthyroidism. In the last two conditions thiouracil has its greatest specific value since other suitable measures exist for the treatment of the majority of cases of thyrotoxicosis. In view of its toxicity, the promiscuous use of thiouracil and its use as a sole method of therapy would certainly seem to be undesirable. However, the introduction of thiouracil has demonstrated that thyrotoxicosis may be controlled by anti-thyroidal agents. Having established this fact it is only necessary to improve upon thiouracil in order ultimately to obtain a compound which lacking the toxicity of thiouracil would certainly greatly modify our present methods of therapy in Graves' disease. Toxic adenoma, being a neoplasia, requires surgery regardless of the ease with which the symptoms of hyperthyroidism might be controlled medically. The methyl derivative of thiouracil has been used in the Scandinavian countries, amino thiazol in France, and the butyl, propyl, methyl, and isopropyl derivatives in this country. My own experience has been limited to the propyl derivative. It is too early to say to what extent toxicity will result from the use of this compound although preliminary studies would indicate that it is less toxic than thiouracil. In my own experience, which, however, is limited to relatively few cases, toxicity (manifested by local edema of the neck) has been observed in only 1 patient.

*Grollman and Gryte: Use of Thiouracil in Thyrotoxicosis, J. Clin. Endocrinol. 4:444-446 (Sept.) 1944.

ARMY INTERNSHIPS TO CARRY RESERVE COMMISSIONS

Eighty-three first lieutenant reserve commissions are available for 1947 medical school graduates who desire internships in Army hospitals, Major General Norman T. Kirk, Surgeon General of the Army, has announced. An annual salary of $2,972 for an officer without dependents, of $3,404 with dependents, goes with the commission. This is a departure from former Army practice when interns were classified as civilian employees and received about $1,000 annually.

The proposed internships are the conventional rotating type, recognized by the Council on Medical Education and Hospitals of the American Medical Association and by state boards of registration.

Deans of accredited medical schools have been requested to recommend men desirable not only as interns, but who will ultimately develop as regular Army medical officers, for with 90,000 patients in Army hospitals throughout the world and prospects of a large peacetime Army, the Army Medical Department is eager to secure young physicians interested in a career in military medicine.

Students may apply for the Army internships through the deans of their schools. An applicant must be a United States citizen, a prospective 1947 graduate of a recognized school of medicine approved by the Council on Medical Education and Hospitals, not more than 30 years of age on July 1, 1947, have no commitment to accept an internship appointment in any other institution, and meet physical standards for appointment in the Medical Corps, U. S. Army. Accepted applicants will be notified.

ACUTE CARDIAC EMERGENCIES

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The acute disorders of the heart may be divided into two general types of which one is concerned with sudden failure of the coronary circulation, producing either angina pectoris or myocardial infarction, and the other with failure of the heart as a whole. The following discussion will not be concerned with the first type but will be confined to those conditions which are characterized by acute failure of the heart as a whole. Such failure is characterized by two different groups of manifestations: those which may be ascribed to "forward failure" and which are dependent on diminished blood supply to the peripheral tissues of the body; and those which are dependent on "backward failure" (back pressure), and which are brought about by engorgement in the pulmonary or systemic circulation.

The clinical manifestations of forward failure of the heart resemble those of acute peripheral circulatory failure (shock) and consist of feebleness of the pulse, lowering of the blood pressure, coldness of the skin accompanied by pallor and often by sweating, plus subjective sensations of weakness and faintness which in severe cases may proceed to actual unconsciousness. However, there are important differences which distinguish forward failure of the heart from peripheral circulatory failure, and these differences consist in the manifestations of congestion or engorgement. Such manifestations are of two types: those occurring in the pulmonary vascular bed (dyspnea, rales at the bases, diminished vital capacity, prolongation of the circulation time, and increased vascular markings as observed by roentgen ray), and those occurring in the systemic vascular bed (distention of the veins, enlargement of the liver, edema, cyanosis, and albuminuria). It is the appearance of such manifestations of congestion either in the pulmonary or systemic vessels which serves to distinguish acute cardiac failure from peripheral circulatory failure. This distinction is important because upon it treatment depends.

One of the most common cardiac emergencies is acute pulmonary edema. This is especially apt to occur in persons with either lesions of the aortic valve, hypertension, or senile myocardial degeneration. The attacks usually set in during sleep and may be precipitated by many factors, of which the most important is probably the sudden reabsorption, in the recumbent position, of tissue fluid from the legs into the blood stream. The chief features of the attack are sudden dyspnea (often accompanied by wheezing and, hence, called "cardiac asthma"), bubbling rales, cyanosis, and the copious expectoration of thin foamy sputum. The treatment consists of morphine (to reduce the sensitivity of the respiratory center to afferent impulses from the legs), aminophyllin (to relieve the associated bronchial spasm), venesection (to reduce the amount of blood in the lungs), and oxygen. Digitalis and diuretic drugs constitute effective measures for preventing further attacks in the majority of patients.

Another common cause of acute failure of the heart is a sudden and marked change in rate caused by the development of an abnormal or ectopic rhythm. The sudden tachycardias include auricular fibrillation, auricular flutter, paroxysmal auricular tachycardia, and paroxysmal ventricular tachycardia. Further discussion concerning the bedside recognition and the clinical management of these conditions will be omitted, as this topic was discussed in a recent publication in the TEXAS STATE JOURNAL OF MEDICINE.

Bradycardia of sufficient degree to produce circulatory failure is of two general types: neurogenic and myogenic. The neurogenic type is usually of reflex origin and the most common such reflex arises in the carotid sinus. Patients with a hypersensitive carotid sinus are subject to sudden attacks of weakness, faintness, and unconsciousness. Such seizures usually occur when the subject is in the upright position and are often precipitated by turning of the head. They last from a few seconds to a few minutes only, and commonly set in suddenly without warning. The diagnosis is established by reproducing the attacks upon pressure of the carotid sinus high in the neck at the point of bifurcation of the common carotid artery. Carotid sinus seizures are of several types but the most common variety is that which is attended by a marked bradycardia. The seizures may be controlled in some patients by the use of atropine, ephedrine, and similar drugs, and at times may be relieved completely by denervation of the carotid sinus. Ordinarily, the condition is not serious except for the possibility of a broken bone. Most of the subjects are elderly men but the condition is not uncommon in women.

There are various other zones in the body from which vagal reflexes may arise. These include the eyes, and this oculocardiac reflex

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is occasionally responsible for syncopal seizures during operative procedures on the eye. Likewise, almost any site in the gastrointestinal tract may give rise to vagal reflexes. Rarely, one observes patients who have syncopal attacks during bowel movements as the result of such a reflex vagal mechanism.

The second, and less common, type of sudden bradycardia is the myogenic variety or heart block (the Adams-Stokes syndrome). This condition usually occurs as the result of senile change either in the myocardium or in the mitral annulus, but may be brought about by rheumatic fever or, less commonly, by other disorders of the heart. Syncopal attacks or semisyncopal attacks may occur either when there is a sudden development of complete auriculoventricular dissociation, or in a person with persistent auriculoventricular dissociation when there is a sudden increase in the degree of pre-existing bradycardia. Such attacks set in abruptly with faintness, unconsciousness, and occasionally with convulsions. If the patient is not seen during the time the bradycardia is present, the diagnosis may be difficult but can often be suspected on the basis of electrocardiographic demonstration of disturbance in auriculoventricular conduction. When the patient is seen during the attack electrocardiographic confirmation is rarely needed, as the clinical signs are usually characteristic. Typically, in complete heart block the intensity of the first sound varies markedly from beat to beat in spite of the fact that the rhythm, while slow, is entirely regular. Likewise, exercise does not increase the heart rate. Another sign occasionally observed is the occasional appearance of a markedly prominent wave in the jugular pulse. This sign occurs when the auricles and ventricles happen to contract simultaneously, and the auricular blood is expelled backward because it cannot be pushed into the already contracted ventricles. Adams-Stokes seizures constitute a serious condition and frequently end fatally. The most valuable drug in treating the attacks is adrenalin, and in preventing them ephedrine and similar long-acting sympatheticomimetic drugs are the measures of choice.

Aside from changes in rate, acute cardiac emergencies may be induced by conditions which lead to sudden injury of the myocardium. The most common such condition is infarction, which will not be discussed in this publication. Less frequent causes of acute and fulminating myocardial injury are diphtheria and rheumatic fever.

Another group of conditions which lead to sudden heart failure are those in which there is sudden mechanical hindrances to the heart. Of these conditions one of the most important, from a practical standpoint, is cardiac tamponade, the condition which arises when fluid suddenly accumulates in the pericardium. One of the common causes of this condition is trauma and, more particularly, stab wounds. In such an instance the fluid which impairs the filling of the heart is blood. It was formerly the custom to operate on such patients but the experience gained during World War II would seem to indicate that tapping of the pericardium and withdrawing a small amount of blood, so that the heart can fill more freely, is safer and is adequate in many instances.

Another cause of cardiac tamponade is acute pericardial infusion, such as may complicate rheumatic fever, pneumonia, and tuberculosis. The decision in a patient presenting a feeble pulse, low blood pressure, and distended neck veins, as to whether sudden myocardial dilatation or pericardial diffusion is responsible is a very important one from a practical standpoint and may at times be difficult. One sign is of especial value in this regard and this is the appearance of the so-called paradoxical pulse in which the blood pressure is considerably lower during inspiration than during expiration. In normal persons the systolic pressure may be 2 to 4 mm. lower during inspiration than during expiration. However, when the difference becomes 10 mm. or more, one has a true paradoxical pulse, and this sign indicates inhibition of cardiac filling. Such inhibition may occasionally be brought about by purely respiratory disorders, such as bronchial asthma, but is most characteristically seen when there is either fluid in the pericardium or marked thickening of the pericardium. The paradoxical pulse is therefore an important sign of cardiac tamponade, and when coupled with the wide area of cardiac dullness, the inability to palpate the apex beat, the muffling of heart sounds, and the presence of a pericardial friction rub becomes pathognomonic. Once the diagnosis of cardiac tamponade has been made the patient should be carefully watched and if the condition is progressing, as indicated by increasing distention of the veins and further diminution in pulse pressure, paracentesis of the pericardium is indicated.

Another common condition which may lead to acute mechanical hindrance to the heart is pulmonary embolism. This occurs especially in patients who have had congestive heart failure, in those who have recently been subjected to operation, or who have been the victims of severe trauma. The onset is sudden and is likely to be attended by

a feeling of substernal pressure resembling that seen in myocardial infarction, plus the later development of a pleural type of pain. Dyspnea may be outspoken. Dilatation of the right ventricle occurs and the veins suddenly become prominent. Although attempts have been made to perform embolectomy on the pulmonary arteries, these are attended by grave hazard and the accepted treatment is conservative management. However, it is much more important to try to prevent pulmonary embolism by preventing the causes of phlebothrombosis. One of the important advances which has occurred as the result of the recent tendency toward early ambulation following surgical and obstetrical procedures has been the lessened frequency of pulmonary embolism. Most such emboli arise in the deep veins of the calf and daily examination of the legs will often reveal calf tenderness or pain in the calves upon forced dorsiflexion of the foot. Such signs may serve as a warning that pulmonary embolism is likely. Some physicians believe that under such circumstances the femoral vein ~~artery~~ on the corresponding side should be ligated, while others hold that this should not be done until evidence of pulmonary embolism has developed and should then be carried out for the purpose of preventing further embolization. Probably within a few years sufficient statistics will have accumulated to give a clear-cut answer to this problem.

There are a large number of interesting but less common conditions which may produce sudden mechanical hindrance to the action of the heart. These include such disorders as obstruction of a stenotic mitral orifice by a ball-valve thrombus arising in the left auricle, obstruction of the mitral orifices by a myxoma of the left auricle, rupture of an aortic or mitral cusp (usually the result of bacterial endocarditis), and rupture of the papillary muscle or of the interventricular septum in a person with a recent myocardial infarction. In some of these conditions little can be done; in others the usual treatment of acute heart failure will suffice. However, such treatment cannot be applied unless the presence of heart failure is recognized and the distinction is made from peripheral circulatory failure or shock. It therefore should be emphasized again that in this important differentiation it is proper attention to and search for the signs of congestion which afford the clue. In many instances simple inspection of the veins of the neck will suffice. These will be found to be invariably empty in persons with peripheral circulatory failure, but they are frequently distended in patients suffering from acute cardiac failure.

ABSTRACT OF DISCUSSION

Dr. James A. Greene, Houston: I would like to congratulate Dr. Harrison for the excellent presentation of this timely subject.

Cardiac asthma is acute left ventricular failure, and the term "cardiac asthma" should be abandoned. There is additional treatment which can be employed—that of applying tourniquets to the extremities, producing a stasis of blood in those extremities during an attack of acute left ventricular failure. This may be used instead of venesection. In cases of Stokes-Adams syndrome, paradrene has been advocated. I used it in 1 case with questionable results. Certainly, in persons who have heart block it may be of definite value.

In cases of cardiac tamponade, decreased excursion of the medial costal margins and a pulling in of the lower sternum will be of definite help in making the diagnosis.

In the stimulation of the carotid sinus, I think it is important to learn to stimulate it properly. If the lower carotid artery is freed and the fingers are worked up medially to it until they reach the bifurcation, only slight stimulation is required. With the fingers medial to the artery, it is possible to stimulate it continuously, whereas if an attempt is made to stimulate it from the lateral aspect or from the anterior aspect, it may be stimulated off and on during the massaging of that region.

Spontaneous emphysema of the mediastinum may stimulate coronary artery disease and has to be taken into consideration of such cases. Likewise cases of hiatus hernia of the diaphragm may stimulate coronary occlusion.

ACUTE RHEUMATIC FEVER IN YOUNG ADULTS

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DALLAS, TEXAS

Acute rheumatic fever is regarded as an endemic disease which primarily affects children. The epidemic nature of the disease involving young adults was not apparent until the recent military emergency, when it made its appearance in epidemic form among the military personnel during the early period of mobilization and was most prevalent in camps located in the Rocky Mountain area.[2, 3, 6, 7, 9, 10] The data presented in this paper summarize a study of the small epidemic of 266 patients that occurred in a large camp in that area[2] (fig. 1).

ETIOLOGY

The most constant feature of the disease is its relationship to group A beta-hemolytic streptococcal infection.[1, 4, 5, 6, 8] Once a person has had rheumatic fever, there exists the predisposition to reactivation with subsequent streptococcal infections. Serologic examination of the blood serum of patients with rheumatic fever shows with great regularity an increase of the antistreptococcus antibodies.

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A total of 91 per cent of the group had preceding acute upper-respiratory infections on an average of sixteen days prior to the onset of the articular phase of rheumatic fever. Seventy-eight per cent had acute nasopharyngitis, including tonsillitis; 6 per cent scarlet fever; 2 per cent measles; and 5 per cent pneumonia. It is presumed that the nasopharyngitis was from hemolytic streptococcus infection because there were large numbers of patients with scarlet fever and an exudative pharyngitis admitted to the hospital. Studies made by a special War Department commission the following year revealed that there were large numbers of upper-respiratory infections caused by the group A beta-hemolytic streptococcus infection.

There were no particular provocative factors other than exposure to cold weather and crowded barracks life. As can be seen by figure 1, the highest number of cases of rheumatic fever, 51, occurred during the month of May. The highest number of patients with acute nasopharyngitis, including 1,200 new cases, was admitted during January. The graphic line in figure 1 shows a definite lag in the number of patients admitted with rheumatic fever as compared with admission of patients with acute upper-respiratory infections.

A total of 21 per cent gave a positive history for rheumatic fever in the parents or siblings. Thirty per cent of the group gave a history of past attacks of acute rheumatic fever, and 4.5 per cent of the total group showed evidence of old, valvular lesions.

INCIDENCE

The ages of the patients in this group ranged from 18 to 42 years of age.

SYMPTOMS AND CLINICAL OBSERVATIONS

All patients had fever ranging up to 104 F., tachycardia, and migratory polyarthritis. Sixty-three per cent had chilly sensations without definite shaking chills. Epistaxis was present in 23 per cent of the group.

Joint involvement was the most striking symptom of onset. Frequently the pain was so severe that opiates were required until therapeutic doses of salicylates were administered. Seventy-three per cent of the group had knee effusions which varied from 10 to 20 cc. in amount.

A total of 45 per cent of the patients developed cardiac abnormalities during the period of observation. A prolonged conduction time of .21 seconds or more was the only abnormality noted in 21 per cent. Significant valvular murmurs were heard in 17 per cent, and acute pericarditis was present in 7 per cent of the group. Cardiac decompensation was noted in only one instance.

Skin lesions were present in 6 per cent of the cases. There were 2 per cent of the cases with erythema marginatum; 1.5 per cent with erythema nodosum and purpura; and 1 per cent with erythema multiforme. Subcutaneous nodules in the olecranon bursa were observed in 2 per cent of the series.

Neurological complications were seen in 3 patients. Two of these patients had a schizophrenic psychosis and 1 had an associated chorea. It was of interest that the psychosis was present prior to therapy and subsequently there was no improvement of the mental condition, even though the arthritis and fever responded to full doses of salicylates.

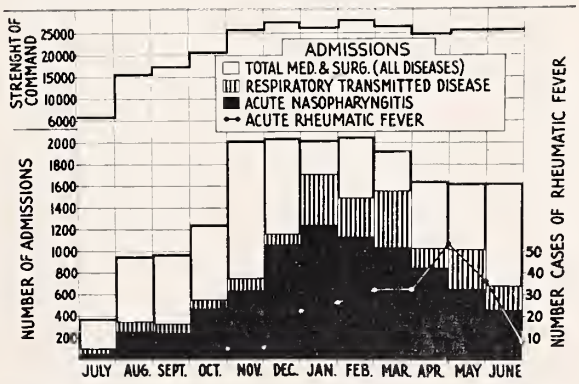

Fig. 1. Relationship of rheumatic fever to respiratory infections.

A marked increase in the sedimentation rate was found constantly.

A leukocytosis was observed ranging between 10,000 and 20,000 per cubic centimeter. Anemia was rarely observed and only 1 patient had less than 3.5 million red cells per cubic millimeter and 85 per cent hemoglobin.

Examination of fluid aspirated from the knee joint revealed an increase in the nucleated cell count up to 23,700 per cubic millimeter. The differential counts of the initial examination revealed that polymorphonuclear leukocytes composed from 60 to 98 per cent of the total cells.

COURSE

The course varied, depending on the severity of the disease. The average hospital stay was three months. The patients were discharged from military service as soon as all clinical evidence of rheumatic activity subsided. No fatalities occurred.

DIAGNOSIS

The manifestations of rheumatic fever in adults are similar to those seen in children except that the initial polyarthritis is more

intense and the cardiac complications seem to be less frequent. Clinically, rheumatic fever may be divided into three phases, namely, (1) an acute upper-respiratory streptococcal infection, (2) a quiescent or latent period, and (3) the phase of rheumatic activity which continues from weeks to years. Such a classification is arbitrary, because recent studies reveal that abnormalities in the electrocardiogram may be seen in the latent period preceding the onset of the acute polyarticular phase. It is entirely possible that rheumatic fever can manifest itself without having the acute febrile polyarthritis, but it is hazardous to make the diagnosis in the absence of joint symptoms. A definite diagnosis should not be made without fulfilling the following criteria: (1) an acute febrile onset, (2) a migratory polyarthritis, (3) a marked elevation in the sedimentation rate, (4) a therapeutic response of the polyarthritis, fever, and pulse rate, after the institution of the toxic doses of salicylates. Abnormalities in the electrocardiographic tracings, especially a delayed conduction time and a leukocytosis, are frequently present.

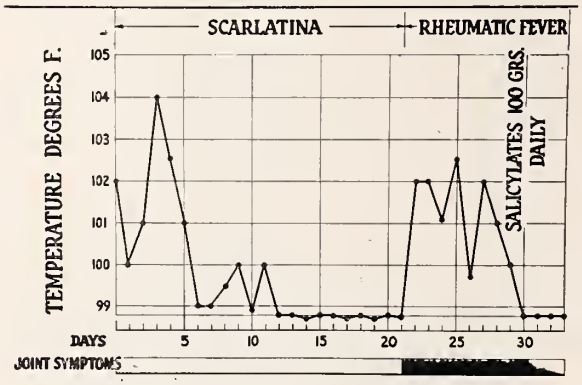

FIG. 2 Temperature graph of a patient who developed acute rheumatic fever following scarlet fever.

Unfortunately, there is no specific test to indicate the presence of rheumatic fever. However, one might suspect its presence when there is a history of an acute upper-respiratory infection followed by an acute febrile polyarthritis. A prompt response of the fever, polyarthritis, and pulse to therapeutic doses of salicylates is the most important diagnostic observation (fig. 2). In some instances, the symptoms may respond to small doses of salicylates, but by and large full toxic doses are required. The usual therapeutic dosage of sodium salicylate is 10 Gm. daily, and if acetyl salicylic acid is used, 8 Gm. should be given. When possible, a blood salicylate level of 35 mg. per 100 cc. is considered adequate. If it is not possible to examine the blood, the doses should be kept just under the amount which will cause ringing of the ears. There is no value in administering sodium salicylate intravenously unless it cannot be given by mouth. An adequate blood salicylate level may be obtained within six hours by giving 50 grains of sodium salicylate in the first dose, followed by 10 grains every hour until a total of 150 grains is given. The level can be maintained if 25 grains of sodium salicylate is given every four hours day and night. The nausea can be controlled by giving 10 grains of sodium bicarbonate with each four hour dose of salicylates. A maximum dose of salicylates should be maintained until the sedimentation rate returns to normal.

There is reason to believe that salicylates have a definite effect on the exudative phenomena of rheumatic fever (fig. 3). The prompt relief of joint pain and swelling is accompanied by similar changes in the synovial fluid. There is a prompt disappearance of excess fluid from the joint space. Administration of salicylates causes a drop in the synovial fluid leukocyte count. A large majority of the abnormal cells in the joint fluid are made up of polymorphonuclear leukocytes, which promptly approach normal values within twenty-four to seventy-two hours after instituting salicylate therapy. In that the joint cavity is a connective tissue space, it reflects tissue abnormalities present elsewhere in the body. Therefore, it is entirely possible that salicylates have a definite effect upon the exudative phenomena of rheumatic fever and thereby shorten the course of the disease and reduce the number of cardiac complications.

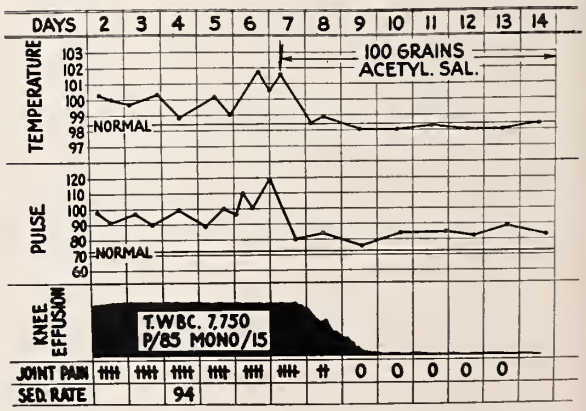

FIG. 3. Response of rheumatic symptoms following administration of 100 grains of acetyl salicylic acid daily. Treatment was started on the seventh day of the disease.

Penicillin[3, 7, 9] and sulfa drugs have no effect on the course of rheumatic fever. However, it is advantageous to administer small doses of sulfadiazine as a prophylac-

tic measure to control the streptococcal respiratory infection and to prevent rheumatic recurrences.

Thus far, attention has been focused on the patient who has developed a permanent rheumatic lesion. It is apparent that emphasis has not been placed on (1) the control of upper-respiratory infections caused by the hemolytic streptococcus and (2) the early recognition and treatment of rheumatic fever in the initial polyarticular phase. Physicians should give special attention to any acute febrile polyarthritis that appears following an acute upper-respiratory infection. The prompt response of symptoms to salicylate medication is indicative of rheumatic fever because other acute forms of arthritis will not receive complete relief. It is further suggested that rheumatic fever be made a reportable disease to the State Board of Health in order to obtain information for the further control of this disease.

SUMMARY

1. Acute rheumatic fever is not confined to children and may make its appearance at any age.

2. In a high percentage of cases the disease is preceded by upper-respiratory infections caused by the group A beta-hemolytic streptococci.

3. The disease affects adults similarly to children, with the exception of the more intense polyarthritis.

4. The most significant clinical feature is its therapeutic response to full doses of salicylates.

5. A total of 45 per cent of adult patients will show cardiac abnormalities during the acute articular phase.

6. Administration of sodium salicylates by mouth will maintain an adequate salicylate level in the blood. The intravenous use of sodium salicylate is contraindicated unless the drug cannot be tolerated by mouth.

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ABSTRACT OF DISCUSSIONS

Dr. Paul J. Thomas, Dallas: We are grateful to Dr. Coggeshall for an excellent presentation of an important subject. He and other physicians in the armed services have clearly shown statistically that rheumatic fever in young adults, as in children, constitutes a grave national health menace capable of epidemic proportions.

It has been estimated that 2 per cent of the first 2,000,000 examinees in World War II were disqualified by Selective Service as a result of rheumatic fever, a disease which is the number one cause of death in the 5 to 24 year age group. Recent studies show a much higher incidence of rheumatic fever in Texas than was originally thought, probably not a lot less than in New England, and constituting the chief cause of death in a Dallas Children's Center.

The establishment of national, state, and municipal rheumatic fever councils appears wise and deserves this Association's active support.

The unequivocal value of sulfonamide prophylaxis should be stressed in view of the group A beta-hemolytic streptococcus-rheumatic fever relationship.

Dr. Coggeshall's diagnostic criteria are important, but not always necessary to diagnosis. Every diagnostic means must be utilized to establish the presence of rheumatic activity.

The continued study of such serologic reaction as the antistreptolysin and electrocardiographic provocative procedures should be encouraged until tests of greater diagnostic specificity are found. When practical, these aids should be made readily available to the clinician.

Until the etiology and pathogenesis are more thoroughly elucidated, therapy must rest largely on the empirical usage of salicylates.

Dr. Alfred W. Harris, Dallas: We are indebted to Dr. Coggeshall for an excellent review of acute rheumatic fever, as he witnessed it in epidemic form. So many excellent points were raised that one is tempted to discuss the paper at great length, but in the time allotted me, I shall attempt to enlarge upon the importance of electrocardiographic variations. With the presence of carditis, either clinical or occult, certain electrocardiographic changes may appear. Unfortunately these changes bear no exact relationship to the height of fever nor to the clinical severity of the disease. For this reason, one must repeat the tracing in serial fashion frequently. The importance of these changes was pointed out as far back as 1923 and 1924, stressing the fact that electrocardiographic changes occur rarely during acute febrile states other than in rheumatic fever. In view of the absence of any specific laboratory tests to make the diagnosis of rheumatic fever, the electrocardiographic changes have been seized upon as one of the mainstays for diagnosis. I believe this rule still holds true, but now that electrocardiographic tracings have been done with greater frequency in other acute febrile illnesses, the result is that electrocardiographic changes are also found to be present, for example, in typhus. This emphasizes that it is still the entire clinical picture upon which the diagnosis of rheumatic fever rests.

The electrocardiographic changes usually seen fall under four headings: (1) prolongation of auriculoventricular conduction time; (2) abnormalities of rhythm; (3) abnormalities of the QRS and T waves; and (4) changes seen with pericarditis.

In the literature, one finds that daily electrocardiograms in patients with active carditis reveal prolongation of the P-R interval in from 12.8 to 84 per cent in various series. It should be remembered that studies by Ashman and Hull reveal that the age of the patient and the heart rate, as well as serial changes with the same heart rate, must be

taken into consideration. Furthermore, Logue's studies on normal persons showed 100 cases of P-R intervals of 0.22 seconds in 6,700 tracings. Whereas formerly the atropine reversal of prolonged P-R intervals was thought to indicate normality, it has now been adequately shown that even in definite carditis, the P-R interval can be shortened with atropine in many instances. Thus it is seen that good judgment is still valuable in assessing P-R time prolongation. By these remarks I do not mean to deny the importance of this observation, for it is still the most consistent change, even though it be transient. Occasional partial A-V block with dropped beats may occur, as well as A-V dissociation. Of the arrhythmias, auricular fibrillation, flutter, premature contractions, and auricular tachycardia, as well as nodal rhythm, are seen. Regarding the changes occasionally seen in the QRS and T waves, one must be a little more careful. When they are seen in serial fashion, there is very little doubt that they signify myocardial changes. I am unwilling to substantiate Wendkos' observation of T wave changes in Lead IV as of diagnostic importance, for in an unpublished series of tests on normal persons in the age group below 30 I was able to find many with T4 abnormal. It is unnecessary to discuss the ST-T changes seen with pericarditis of any type.

These, then, are the electrocardiographic changes of help in diagnosis of acute rheumatic fever. In terms of prognosis, there is less safe footing. The prolonged P-R interval may remain throughout life, although it usually disappears within one to six months. Altschule believes that if the P-R prolongation continues, such patients are more susceptible to auricular fibrillation. In general, electrocardiographic abnormalities are of no great value in prognosis except that once they are abnormal and then recede such normality is somewhat comforting to the physician.

MAJOR SURGERY OF THE SUPPURATIVE PARANASAL SINUSES

CLAUDE D. WINBORN, M. D.
DALLAS, TEXAS

The role of major surgery in the treatment of infections of the paranasal sinuses has diminished to such an extent that today one seldom sees the case that cannot be properly cared for by more conservative means. This is no doubt the result to some extent of chemotherapy but credit must be given the rhinologist for a more enlightened type of therapy in the acute stages of sinus disease. More attention is being given the constitutional aspect of the disease with local therapy based on the idea that with proper support the sinuses are thoroughly able to care for themselves.

In evaluating the effects of surgery on the nose one must consider some of its physiology. The principal functions of the nose are the humidifying and warming of inspired air and the filtering out of foreign particles including bacteria which are destroyed by the enzyme-lysozyme contained in nasal secretions. The air pathway, principally through the middle meatus, is warmed by the highly vascular turbinates and humidified by evaporation from the mucous sheath covering the entire nasal mucosa. The mucous sheath is moved posteriorly on top of the cilia of the surface cells and is said to be completely changed as much as three times every hour. Therefore one should preserve as far as possible the mucosa with its mucous glands and ciliated surface cells and the turbinates with their cavernous spaces and large surface area in their normal size and relationship. Complete or partial amputation of a turbinate should be done only after thorough consideration of its effect on the normal function of the nasal cavity.

In sinus surgery thoroughness cannot be overemphasized. A single diseased cell left unopened in an acute fulminating infection will likely mean a failure and loss of the patient. Similarly, a diseased cell left intact in the chronic conditions means persistence of the disease and re-operation. In no other region of the body is there such variation in the anatomy as in the sinuses. Consequently this is one of the most difficult of surgical fields. One must know the anatomy of the region thoroughly and must be aware of the possible extreme variations from the average in order to keep out of danger and to do a complete exenteration. Radiographs are valuable aids in the delineation of the antrums and frontals but are much less useful where the sphenoids and ethmoids are concerned. Under certain conditions roentgen ray examination has been found to be actually misleading. A good surgical knowledge and judgment is of primary importance with other factors playing a role of useful aids.

Indications for surgical interference in sinus infections should be carefully evaluated. Adequate conservative measures for the promotion of intranasal drainage should be carried out before surgery is considered. Perhaps more than any other field of surgery the ultimate result must be considered since little can be done to correct the results of an ill advised sinus operation. Rhinological surgery is slowly recovering from a reputation of promiscuity.

In the acute stages of sinusitis, surgery should be limited to the very virulent, fulminating infections with impending serious complications. It is difficult to evaluate the extent of infection in these cases and it should be remembered that a high morbidity and mortality attends surgical intervention. Where there is marked toxicity with edema of the lids, exophthalmos, and proptosis, an external or so-called radical exenteration of

From the Department of Otolaryngology, Southwestern Medical College.
Read before the Section on Eye, Ear, Nose, and Throat, State Medical Association of Texas, Annual Session, May 8, 1946.

the ethmoids should be done. If the frontal and sphenoid are involved, the floor of the frontal and the face of the sphenoid should also be removed. Fortunately the fulminant sinus is infrequent and is usually self limiting to orbital edema or abscess and in most cases responds well to conservative treatment. Irrigation of an acute antrum or infraction of the anterior tip of the middle turbinate in acute frontals sinusitis have not been universally accepted but when judiciously employed have been found valuable and relatively safe.

In chronic suppuration there is no immediate danger to the life of the patient unless complicated by extension into neighboring regions. Adequate conservative care should be carried out before surgery is decided upon. Attention should be given drainage and ventilation of the meatus involved. There is usually a deflected septum, polypus, or a hypertrophic cellular middle turbinate which requires attention. Chronic conditions which may require surgery for relief are (1) purulent drainage with headache and malaise which persists after adequate treatment, (2) optic neuritis, (3) extensions into neighboring regions, and (4) existence of a focus of infection in the sinuses which stimulates disease in another region or an allergy from bacterial protein sensitization.

With the exception of the antrum window, intranasal operations are more tedious and risky than those with an external approach. There are many important structures adjacent to the sinus walls and with the marked variety of sizes and shapes of the sinuses it is not always possible to determine when these structures are approached. For the same reason a diseased cell or cells may be left intact with a consequent continuance of the condition that was supposedly being corrected. Many rhinologists prefer the intranasal operation as the operation of choice in most cases and rely on the external in event of failure. No doubt the intranasal route is relatively safe in experienced hands and successful where the disease is limited to easily accessible cells. A diseased sphenoid when unaccompanied by posterior ethmoiditis should be operated on by this route but this condition seldom occurs alone. A compact group of anterior ethmoid cells may be exenterated intranasally. Excepting the antrum the most frequent sinus conditions that resist treatment are combinations of sphenoid and posterior ethmoid, frontal and anterior ethmoid, or a pansinusitis and these should be operated on by the external or radical method.

The most common objection to the external operation is deformity caused by removal of the outer wall of the frontal sinus and resulting in a depression. It is seldom found necessary to remove the outer wall of the frontal as this sinus may be cleaned out after removal of the floor in most cases. Some operators prefer to do a partial intranasal ethmoidectomy before beginning the external approach providing a dryer field with better visibility. This has not been found to be of such an advantage as to warrant the extra time and effort. If the ethmoid region has been previously packed with adrenalin soaked cotton and the posterior ethmoid vessels ligated, bleeding will not be much of a handicap. It may be found that some cells are more easily removed intranasally and it is relatively simple to interchange repeatedly from one route to the other. It seems reasonable to believe that the middle turbinate should invariably be removed during the operation but this is not universally agreed upon. With the organization of fibrous tissue the formation of recesses and pockets with a retention of pus may occur even with this turbinate absent. The retention of the turbinate would also make the after care more difficult.

The external operation favored by most operators and which is most uniformly successful is a modification of the Killian. A detailed description of this operation will be found in many modern textbooks. The incision begins in the lower edge of the eyebrow at a point depending on the size of the frontal sinus and extending medially to curve downward around the inner canthus of the eye. By entering the ethmoid capsule through the posterior wall of the lacrimal fossa, the most anterior ethmoid cell may be removed. After all the ethmoid cells are exenterated and the anterior wall of the sphenoid is taken down, the floor of the frontal sinus is removed and all the mucosa cleaned out. A useful aid in the latter procedure is a mirror small enough to be inserted through the open floor. A mucosal flap or skin graft in this cavity will facilitate drainage and minimize granulations.

Operations on the suppurative maxillary antrum are performed for two purposes. One is to obtain more adequate drainage and ventilation and the other to remove an irreparably damaged lining. The first objective is accomplished by opening a window under the inferior turbinate and is reasonably successful in providing a more healthful atmosphere in the sinus and promoting healing in a large number of retractable cases. The second objective is accomplished by means of the external or radical operation in which an opening is made sublabially through the canine fossa and the entire lin-

ing is stripped out. Ventilation, drainage, and further access to the sinus is provided for by a large window in the inferior meatus. A thickened lining membrane is not sufficient indication for its removal. Many of these cases are found on roentgen examination to be either nonsymptomatic or an allergic manifestation. In long continued infections with a purulent discharge the mucosa becomes a boggy mass with eventual polypoid degeneration. An organization of the exudate produces recesses and pockets for the collection of pus, which interfere with normal drainage and prevent resolution. Removal of this type of membrane is the only successful means to a cure.

Medical Arts Bldg.

ABSTRACT OF DISCUSSION

Dr. John L. Jenkins, Dallas: With the advent of sulfa drugs the otolaryngologist began to view with alarm his security and complacency in medical and surgical practice. A short few years later he was again apprehensive when penicillin and allied antibiotics came into use. At this time after several years experience with those drugs otolaryngologists realize that the drugs are only an adjunct. The too free indiscriminate use of these drugs by general practitioners and pediatricians for otolaryngologic conditions is probably adding to instead of decreasing the amount of work in the otolaryngologic field. It is my conviction and contention that the normal process of immunity is greatly interfered with where antibiotics are administered early in acute upper respiratory diseases. It has been too easy during these war times to order antibiotics to satisfy people and parents. Just what the results of such practice will be in ten years from now I cannot prophecy. Now to jump to the other side of the fence in justification of the antibiotic drugs, they have very definitely cut down on rhinologic as well as otolaryngologic surgery. The indications for radical surgery remain as they always were but these indications are less frequently seen, principally because of antibiotics and the more intelligent handling of the early conditions which bring on these indications.

MISCELLANEOUS

COMING MEETINGS AND CLINICS

State Medical Association of Texas, Dallas, May 5-8, 1947. Dr. C. C. Cody, Jr., Houston, President; Dr. Holman Taylor, 1404 W. El Paso St., Fort Worth 3, Secretary.

American Medical Association, House of Delegates, Chicago, December 9-11, 1946; Regular General Session, Atlantic City, N. J., June 9-13, 1947. Dr. Harrison H. Shoulders, Nashville, Tenn., President; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secretary.

Southern Medical Association, Miami, Fla., November 4-7, 1946. Dr. M. Y. Dabney, Birmingham, Ala., President; C. P. Loranz, Empire Building, Birmingham, Ala., Secretary-Manager.

Southwest Allergy Forum, Shreveport, La., March 31-April 1, 1947. Dr. W. H. Browning, Shreveport, La., President; Dr. Sim Hulsey, Medical Arts Bldg., Fort Worth, Secretary.

Texas Association of Medical Anesthetists, Dallas, May 5, 1947. Dr. Claudia Potter, Temple, President; Dr. Russell Bonham, Box 6237, Houston, Secretary.

Texas Association of Obstetricians and Gynecologists, Galveston, November 2, 1946. Dr. Allen McMurrey, Houston, President; Dr. Julius McIver, 714 Medical Arts Building, Dallas, Secretary.

Texas Chapter, American College of Chest Physicians, May 5, 1947. Dr. R. G. McCorkle, San Antonio, President; Dr. Elliott Mendenhall, 1217 Medical Arts Bldg., Dallas, Secretary.

Texas Club of Internists. Dr. Robert M. Barton, Dallas, President; Dr. Julian C. Barton, 414 Navarro St., San Antonio, Secretary.

Texas Hospital Association, Houston, March 27-29, 1947. Tol Terrell, Harris Memorial Methodist Hospital, Fort Worth, President; Mrs. Ruth Barnhart, 2210 Main St., Dallas., Secretary.

Texas Neuropsychiatric Association, Dallas, May 5, 1947. Dr. Fred T. Rogers, Dallas, President; Dr. David Wade, 604 Capital National Bank Bldg., Austin, Secretary.

Texas Ophthalmological and Otolaryngological Society, Dallas, December 6-7, 1946. Dr. C. H. Brooks, Waco, Acting President; Dr. E. D. Dumas, 425 Medical Arts Bldg., San Antonio, Secretary.

Texas Orthopedic Society. Dr. E. A. Cayo, San Antonio, President; Dr. Edward Smith, 1215 Walker Ave., Houston, Secretary.

Texas Pediatric Society, Houston, October, 1947. Dr. J. R. Lemmon, Amarillo, President; Dr. John E. Ashby, 3610 Fairmount, Dallas, Secretary.

Texas Public Health Association, Dallas. Dr. L. P. Walter, Austin, President; Mr. Earle W. Sudderth, Dallas County Health Department, Court House, Dallas, Secretary.

Texas Radiological Society, Houston, January 25, 1947. Dr. Herman Klapproth, Sherman, President; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secretary.

Texas Railway and Traumatic Surgical Association, May 5, 1947, Dr. F. L. Snyder, Fort Worth, President; Dr. Ross Trigg, First National Bank Bldg., Fort Worth, Secretary.

Texas Society for Mental Hygiene, San Antonio, April 10-12, 1947. Dr. Jack R. Ewalt, University of Texas Medical Branch, Galveston, President; Mrs. Elizabeth F. Gardner, 1617 Watchhill Road, Austin 21, Executive Secretary.

Texas Society of Gastro-Enterologists and Proctologists, Dallas, May 5, 1947. Dr. Tom E. Smith, Dallas, President; Dr. D. L. Curb, 704 Dallas Ave., Houston, Secretary.

Texas Society of Pathologists, Houston, January, 1947. Dr. May Owen, Fort Worth, President; Dr. C. T. Ashworth, Southwestern Medical College, Dallas, Secretary.

Texas State Heart Association, Dallas, May 5, 1947. Dr. Robert M. Barton, Dallas, President; Dr. M. B. Whitten, Medical Arts Bldg., Dallas, Secretary.

Texas State Urological Society, Houston, December 2, 1946. Dr. Joe C. Alexander, Dallas, President; Dr. Michael K. O'Heeron, 901 Medical Arts Bldg., Houston, Secretary.

Texas Surgical Society, Dallas, April, 1947. Dr. Walter Stuck, San Antonio, President; Dr. Truman G. Blocker, University of Texas Medical Branch, Galveston, Secretary.

Texas Tuberculosis Association. F. K. Dougharty, Liberty, President; Miss Pansy Nichols, 700 Brazos, Austin, Executive Secretary.

Third Panhandle, District Medical Society, Amarillo, Spring, 1947. Dr. W. A. Carroll, Claude, President; Dr. George Powers, Fisk Bldg., Amarillo, Secretary.

Fourth District Medical Society. Dr. H. L. Locker, Brownwood, President; Dr. Glenn H. Ricks, Brady, Secretary.

Seventh, Austin, District Society. Dr. Robert B. Morrison, Austin, President; Dr. M. I. Brown, Capital National Bank Bldg., Austin, Secretary.

Eighth, Ninth and Tenth Districts Medical Society, Orange, April, 1947. Dr. Walter F. Hasskarl, Brenham, President; Dr. George W. Waldron, Medical Arts Bldg., Houston, Secretary.

Eleventh District Society. Dr. L. L. Travis, Jacksonville, President; Dr. C. B. Young, 929 S. Confederate, Tyler, Secretary.

Twelfth, Central Texas, District Society, Temple, January 14, 1947. Dr. Thomas G. Glass, Marlin, President; Dr. H. F. Connally, Jr., Amicable Bldg., Waco, Secretary.

Thirteenth, Northwest District Society, Abilene, Spring, 1947. Dr. Frank Hodges, Abilene, President; Dr. Robert C. Stokes, 501 First National Bank Bldg., Fort Worth, Secretary.

Fourteenth District Society, Dallas, December 10, 1946. Dr. C. B. Thayer, Gainesville, President; Dr. V. L. Tuck, Sherman, Secretary.

Fifteenth, Northeast Texas, District Society. Dr. Joe Roberts, Longview, President; Dr. S. W. Tenney, Marshall, Secretary.

CLINICS

Dallas Southern Clinical Conference, Dallas, March 17-20, 1947. Miss Thelma J. Webb, 1133 Medical Arts Bldg., Dallas 1, Executive Secretary

International Postgraduate Medical Assembly of Southwest Texas, San Antonio, January 29-31, 1947. Dr. A. Fletcher Clark, 827 Medical Arts Building, San Antonio, President.

New Orleans Graduate Medical Assembly, New Orleans, February 24-27, 1947. Dr. Max M. Green, Room 105, 1430 Tulane Ave., New Orleans 13, Secretary.

Post Graduate Medical Assembly of South Texas, Houston, December 3-5, 1946. Secretary, 229 Medical Arts Building, Houston.

HOSPITALS NEEDING INTERNS AND RESIDENTS

Methodist Hospital, Dallas. Capacity 206 beds. C. B. Fielder, Superintendent (interns desired, July, 1947).

El Paso City County Hospital, El Paso. Capacity 192 beds. George W. Cook, Col., U. S. A., Ret., Superintendent (3 interns for one year term, graduates of class A medical school only).

Nix Memorial Hospital, San Antonio. Capacity 145; admissions 4,988. Miss A. Pearl Smith, Administrator (intern or resident now; application for intern or resident July 1, 1947).

MEDICAL OFFICERS RETURNING TO TEXAS*

NAME	Serv†	Location	Release Date
Anderson-Houston-Leon Counties			
7. Goolsby, Carl B.	A	Crockett	
Angelina County			
5. Burch, Joseph S.	A	Lufkin	
Armstrong-Donley-Childress-Collingsworth-Hall Counties			
2. Baldwin, Russell E. G.	N	Memphis	
Baylor-Knox-Haskell Counties			
5. Plasek, W. W.	N	Rule[1]	
Bexar County			
137. Bergfeld, Jack A.	A	San Antonio	
138. Berchelmann, David A.	N	San Antonio	July, 1946
139. Blanco, Victor M.	N	San Antonio	
140. Burk, Joseph E.	A	San Antonio	
141. French, Jack A.	A	San Antonio	
142. Heck, William H.	A	San Antonio	
143. Kirksey, O. T.	A	San Antonio	
144. Manhoff, Louis J., Jr.	A	San Antonio	June, 1946
145. Mims, James L., Jr.	A	San Antonio	
146. Moore, Oliver S., Jr.	N	San Antonio	
147. O'Gorman, William D.	A	San Antonio	
148. Ostendorf, Walter A.	A	San Antonio	
149. Pyterek, Arthur B.	A	San Antonio	
150. Rabinowitz, George E.	A	San Antonio	
151. Ressmann, Arthur C.	A	San Antonio	
152. Sawtelle, William W.	N	San Antonio	
153. Siever, James M.	A	San Antonio	
154. Tennison, Charles W.	N	San Antonio	
155. Thaddeus, Aloysius P.		San Antonio[2]	
156. Wolma, Fred J., Jr.	N	San Antonio	
Bosque County			
3. Archer, James T., Jr.	A	Meridian	
Caldwell County			
4. Nassour, Herbert R., Jr.	A	Lockhart	
Cameron-Willacy Counties			
16. De La Garza, Henry	A	Brownsville	
17. George, James C., II	A	Brownsville	
18. Langner, Charles A. G.	A	Brownsville	
19. Parker, Stephen M.	A	Olmito	
Cass-Marion Counties			
4. Joslin, Blocker H.	A	Atlanta	
Cherokee County			
6. McQuaide, Henry C., Jr.	N	Jacksonville	
7. Scarborough, James S.	A	Rusk	
Clay-Montague-Wise Counties			
5. Shilling, Harold	A	Bridgeport[3]	
Cooke County			
5. Clark, Richard G.	A	Gainesville	
Coryell County			
4. Landry, L. B.		Gatesville	
5. Lowrey, Wendell	A	Gatesville	
Dallam-Hartley-Sherman-Moore Counties			
1. Brown, Arnold L.	N	Dalhart	
Dallas County			
204. Acker, Julian H.	N	Dallas	Aug., 1946
205. Adams, George	A	Dallas	
206. Bagwell, John S.	A	Dallas	
207. Brown, S. R.	A	Dallas	
208. Brown, William W., Jr.	A	Dallas	
209. Burnside, Ronald M.	A	Dallas	
210. Buzbee, H. Ray	A	Dallas	
211. Clark, Fannie M.	N	Dallas	Oct., 1945
212. Denton, Guy T., Jr.	A	Dallas	
213. Fuqua, William N., Jr.	A	Dallas	
214. Johnson, Cecil A.	A	Dallas	Feb., 1946
215. Jones, William E.	A	Dallas	
216. Lauck, Robert E.	A	Dallas	Feb., 1946
Dallas County—Continued			
217. Long, W. E.	A	Dallas	
218. Maddox, Azzie D.	A	Dallas	
219. Mason, Eugene E.	A	Dallas	Feb., 1946
220. Pickle, C. R.	A	Dallas	Jan., 1946
221. Piranio, Joe C.	N	Dallas	
222. Talley, Robert W.	N	Dallas	
223. Taylor, Homer A., Jr.	A	Dallas	
224. Winkelmann, Eugene C.		Dallas	
225. Winn, Robert E.	N	Dallas	
Dawson-Lynn-Terry-Gaines-Yoakum Counties			
11. Cole, Edward L.	A	Lamesa	
DeWitt County			
4. Westphal, Robert D.	A	Yorktown	
Eastland-Callahan Counties			
7. Pruet, Royce W.	N	Eastland	
Ector-Midland-Martin-Howard-Andrews-Glasscock Counties			
15. Blair, James R., Jr.	A	Big Spring	
16. Jones, Roy V., Jr.	N	Big Spring	
17. Lillie, G. V.	N	Odessa	
El Paso County			
58. Allen, George B.	A	El Paso	
59. Callaway, Sam E.	N	El Paso	
60. Craige, Ernest	A	El Paso	
61. Eden, George F.	A	El Paso	
62. Hargrove, Eugene A.	A	El Paso	
63. Johnson, Bascom, Jr.	A	El Paso	
Erath-Hood-Somervell Counties			
4. Hocott, Joseph F.	A	Stephenville	
5. Shepard, Groom S.	A	Alexander	
Falls County			
8. Cornwell, Charles H.	A	Marlin	
Galveston County			
57. Bellegie, Nicholas J.	N	Galveston	
58. Bravo-Fernandez, Enrique J.	A	Galveston	
59. Fuste, Carlos E., Jr.	N	Galveston	
60. Gready, Thomas G., Jr.	N	Galveston	
61. White, Roland L.	N	Galveston	
Gray-Wheeler Counties			
9. Brown, Arnold L.	N	Pampa	
10. Hamer, James G.	A	Shamrock	
11. Howze, Jo W.	A	Pampa	
Grayson County			
14. Little, Frank J.	A	Sherman	
Gregg County			
16. Adams, James N.	N	Longview	
Hardin-Tyler Counties			
4. Tennison, George D.	N	Silsbee	
Harris County			
262. Axelrod, William	A	Houston	
263. Brewer, Thomas W.	A	Houston	
264. Bryan, John N.	N	Houston	
265. Calma, Victor C.	N	Houston	
266. Chalmers, Presley H.	N	Houston	
267. Collette, Allan	N	Houston	
268. Entzminger, Lindell B.	A	Houston	
269. Hargrove, Carey J.	N	Houston	
270. Herndon, Ray F.	N	Houston	
271. Jones, Craig S.	N	Houston	
272. Orr, Charles W.	A	Houston	
273. Reed, Roy W.	A	Houston	
274. Scott, John H.	N	Houston	
275. Secrest, Pettus G., Jr.	A	Houston	
276. Vanzant, Thomas J.	A	Houston	
277. Withers, Henry W.	N	Houston	
Hunt-Rockwall-Rains Counties			
13. Cameron, Harold B.	A	Commerce	
14. Carruthers, Frank S.	A	Commerce	
15. Connor, Marvin M.	A	Commerce	
16. Rix, Robert A., Jr.	N	Commerce	
Jefferson County			
55. Fuqua, William C.	A	Beaumont	
Johnson County			
6. Smyth, O. T., Jr.	N	Alvarado[1]	June, 1946
Kerr-Kendall-Gillespie-Bandera Counties			
14. Gaddy, H. R.	N	Fredericksburg	Aug., 1946
Lampasas-Burnet-Llano Counties			
4. Hoerster, Samuel A., Jr.	N	Llano	
La Salle-Frio-Dimmitt Counties			
5. Wilson, William S., Jr.	A	Carrizo Springs	

*EDITOR'S NOTE: This list is the thirteenth of a series in which it is hoped to name all those physicians who have been in the Armed Forces during the war recently passed and have now returned to Texas to resume civilian practice. The information in this list has been assembled from a variety of sources. While an attempt has been made to secure as complete and as accurate data as possible, we are aware that omissions and errors have been made. Not only for publication in the JOURNAL but also for the permanent records in the central office of the State Medical Association, we invite and urge correction of and addition to the material here submitted. Note that physicians from each county area are numbered consecutively following those listed in the October JOURNAL; the last number in each section therefore indicates the total physicians returned to that county area. The complete total for Texas named to date (October 30), including the accompanying list, is 1,852.

†A=Army; N=Navy; U=U. S. Public Health Service.

[1]Formerly of Breckenridge.

[2]Formerly of Kenedy.

[3]Formerly of Fort Worth.

[1]Formerly of Cleburne.

NAME	Serv†	Location	Release Date
Lavaca County			
6. Clayton, Stanley L.	A	Hallettsville	
7. Williams, Robert W.	A	Shiner	
Lee County			
2. Hejtmancik, Milton R.	A	Giddings	
Lubbock-Crosby Counties			
23. Allensworth, John C.	A	Lubbock	
24. Cobb, John L.	A	Lubbock	
25. Cogburn, Harold N.	N	Lubbock	
26. Hale, Lee E.	A	Lubbock	
27. Keith, Luther M., Jr.	N	Lubbock	
McLennan County			
48. Colgin, James H.	A	Waco	
49. Krueger, Kenneth W.	A	Waco	
50. Tabb, K. Stewart	N	Waco	
51. Yeager, Charles L.	A	Waco	
Medina-Uvalde-Maverick-Val Verde-Edwards-Real-Kinney-Terrell-Zavala Counties			
9. Bartlett, Martin H.	A	Uvalde	Dec., 1945
Milam County			
4. Baskin, John L.	N	Cameron	
Nacogdoches County			
5. Campbell, George M.	A	Nacogdoches	
6. Pennington, T. J., Jr.	N	Nacogdoches	
Nueces County			
36. Barnard, James L.	N	Corpus Christi	
37. Ellis, Frank A.	N	Corpus Christi	
38. Kennedy, Hugh A.	A	Corpus Christi	
39. Stroud, Sanders K.	A	Corpus Christi	
Orange County			
3. Anderson, Roland B.	N	Orange	
Pecos-Jeff Davis-Presidio-Brewster Counties			
5. Barrett, Maurice E.	A	Fort Stockton	
Polk-San Jacinto Counties			
3. Bergman, Sol H.	A	Livingston	
Randall-Deaf Smith-Parmer-Castro-Oldham Counties			
5. Barnett, Lewis B.	N	Hereford	
Tarrant County			
83. Beavers, Alonzo J., Jr.	A	Azle	
84. Roberts, Albert D.	A	Fort Worth	
Tom Green-Coke-Crockett-Concho-Irion-Sterling-Sutton-Schleicher Counties			
22. Arledge, Robert M.	A	San Angelo	
Travis County			
55. Bagwell, Robert W.	N	Austin	
56. Clifford, William S.	N	Austin	
57. Marsh, George B., Jr.	N	Austin	
58. Thomas, John F.	N	Austin	
Walker-Madison-Trinity Counties			
10. Thomason, Robert H.	N	Huntsville	
Wharton-Jackson-Matagorda-Fort Bend Counties			
17. Schaffer, Randolph L.	A	Rosenberg	
Wichita County			
26. Arrington, John H., Jr.	A	Wichita Falls	
27. Atkins, Richard D.	A	Wichita Falls	
Wood County			
4. Tottenham, Edwin P.	A	Mineola	June, 1946

NEW MOTION PICTURES FOR THE FILM LIBRARY

The Motion Picture Film Library of the State Medical Association has received the following films from the Texas Tuberculosis Association for relending:

Routine Admission Chest X-Ray in General Hospitals. 16 mm., sound, showing time, 20 minutes. This picture is part of a campaign to extend mass radiography into general hospital practice as a routine admission procedure for all patients and personnel. It briefly pictures the advantages of such a procedure, gives a few case histories, and brings out the danger of tuberculosis existing undiagnosed in hospitals. It highlights the importance of finding early and treating appropriately non-tuberculous as well as frankly tuberculous conditions in hospital patients. It is of special importance and interest to hospital administrators, radiologists, chest specialists, medical societies, nurses' associations, x-ray technicians, and administrative personnel of health agencies.

Techniques of Group Chest X-Ray Services. 16 mm., sound, showing time, 20 minutes. This is an orientation film for all public health personnel in the proper techniques employed for successful community mass radiography. It outlines the interagency coöperation and planning needed prior to mass radiography operations; covers the details and planning needed for actual operation of a project; describes the equipment, techniques, and personnel needed for each individual project; runs through all operations chronologically; and closes with an effective plea for adoption and coöperation along the lines described.

HEART RESEARCH GRANTS ANNOUNCED

The Life Insurance Medical Research Fund, supported by 149 legal reserve life insurance companies in the United States and Canada to sponsor research in the cardiovascular diseases, recently announced awards of eleven fellowships and grants-in-aid which brought the total of this year's allocation of research funds to nearly $700,000. Dr. Francis R. Dieuaide, scientific director, in announcing the grants, also revealed that applications for research fellowships for 1947 will close on January 1, 1947, and for grants-in-aid on January 31. Dr. Dieuaide, clinical professor of medicine, College of Physicians and Surgeons, Columbia University, New York, indicated that junior fellowships usually range from $1,500 to $2,000 per year and senior fellowships from $2,500 to $3,500.

GASTROENTEROLOGICAL AWARD TO BE GIVEN

An award of $100 and a certificate of merit will be given for the best unpublished contribution on gastroenterology or allied subjects by the National Gastroenterological Association in 1947, the association has announced. Contestants residing in the United States must be members of the American Medical Association, and entries must be in the hands of the association, 1819 Broadway, New York 23, by April 1, 1947.

Manuscripts are limited to 5,000 words and must be submitted in quintuplicate. Announcement of the winner will be made at the annual convention of the association in June, 1947, and exclusive right to publish the winning contribution and others which may receive certificates of merit is reserved by the association for its *Review of Gastroenterology.*

HEART DISEASE CAMPAIGN OPENED

The American Heart Association, supported by more than a dozen national medical and health groups, has initiated a nationwide program of public education and information on diseases of the heart, with emphasis on educational work with schools, parent-teacher associations, and other groups concerned with children. The association points out that fatalities ascribed to heart diseases are greater than the total of the next five leading causes of death and that it is estimated more than 4,000,000 persons in the United States now suffer from heart disease.

The American Legion and its auxiliary, each of which last May allocated $25,000 to be used to combat rheumatic heart disease, have just awarded two fellowships through the American Heart Association to physicians for the study of this problem.

TEXAS PEDIATRIC SOCIETY

The Texas Pediatric Society held its fall clinical meeting October 4-5 at the Texas Hotel, Fort Worth,

under the auspices of District 4. Dr. Max R. Woodward, Sherman, president, presided. There were 112 registered, including several visitors from New Mexico, Louisiana, Oklahoma, and Arizona.

Dr. J. R. Lemmon, Amarillo, was named president; Dr. C. B. Alexander, San Antonio, president-elect; Dr. John E. Ashby, Dallas, secretary-treasurer; and Dr. L. O. Godley, Fort Worth, counsellor of the Fort Worth district. Houston was selected to be host for the 1947 meeting, the exact date in October to be decided later.

Guest speakers for the program included Dr. Joseph A. Johnston, pediatrician-in-chief, Henry Ford Hospital, Detroit; Dr. Edward Pratt, national research fellow in pediatrics, Yale University, New Haven, Conn.; Dr. Daniel C. Darrow, Department of Pediatrics, Yale University, New Haven, Conn.; and Dr. J. Franklin Campbell, dermatologist, Fort Worth. The following papers were presented:

October 4

Tissue Composition in Relation to Water Balance Disturbance—Dr. Darrow.
Thyroid Deficiency in the Growth Period—Dr. Johnston.
Some Common Dermatologic Problems in Children—Dr. Campbell.
The Improved Outlook in Nephrosis—Dr. Johnston.
Water Balance—Dr. Darrow.
Prematurity—Dr. Pratt.
Some Physiological Studies in Convalescence—Dr. Johnston.

October 5

Meningitis—Dr. Pratt.
Adolescence—Dr. Johnston.
Treatment of Diarrhea—Dr. Darrow.

A luncheon and banquet were held October 4, and wives of attending pediatricians were also entertained.

Dr. C. S. E. Touzel was chairman of the local general arrangements committee, which also included Drs. Tom W. Black, Frank Cohen, L. O. Godley, Edwin G. Schwartz, J. L. Spivey, C. O. Terrell, C. O. Terrell, Jr., and Edward M. Wier.

TEXAS SURGICAL SOCIETY

Texas Surgical Society held its fall meeting October 7-8 at Houston with headquarters at the Rice Hotel and the scientific program at the Harris County Medical Society Auditorium in the Medical Arts Building. About ninety members were present for the semi-annual meeting, which included a tour of the recently completed U. S. Naval Hospital, a cocktail party, and a formal dinner in addition to the scientific papers and business session.

Dr. Walter Stuck, San Antonio, secretary of the society for seven years, was elected to the presidency. Dr. M. B. Stokes, Houston, was elected first vice-president; Dr. Joe McGuire, Dallas, second vice-president; and Dr. T. G. Blocker, Galveston, secretary; with Dr. C. B. Carter, Dallas, being reëlected treasurer, and Dr. G. W. N. Eggers, Galveston, recorder. Dr. R. J. White, Fort Worth, was named to the council. Drs. Reese Blundell, Howard Barkley, and Thomas Cronin, all of Houston, were elected to membership. The next meeting of the society will be held in Dallas next April.

The scientific program was as follows:

October 7

Diaphragmatic Hernia—Dr. T. A. Pressly, San Antonio.
Meckel's Diverticulum: Pathological Study of 155 Specimens—Dr. C. D. Bussey, Dallas.
Surgical Treatment of Congenital Heart Disease—Dr. J. W. Duckett, Dallas.
Hernia through Mesenteric Defect with Gangrene of the Small Intestine—Dr. R. J. White and (by invitation) Dr. W. P. Higgins, Fort Worth.
A New Radium Applicator for Cervical and Body Cancers—Dr. John T. Moore, Houston.
Arthroplasty of Tempero-Mandibular Joint in Children—Dr. G. W. N. Eggers, Galveston.
Treatment of Peptic Ulcer by Section of the Vagus Nerve—Dr. R. Arnold Griswold, Professor of Surgery, University of Louisville, Louisville, Ky.
Treatment of Advanced Malignancies of the Rectum and Rectosigmoid—Dr. R. Lee Clark, Director, M. D. Anderson Hospital for Cancer Research, Houston.
Proctology in the Nineties—Dr. Curtice Rosser, Dallas.

October 8

Report of the Use of a Buried Nonabsorbable Continuous Suture—Dr. Joe T. Gilbert, Austin.
Management of the Diabetic Patient During Surgical Procedures—Dr. James A. Greene, Professor of Medicine, Baylor University College of Medicine, Houston.
Treatment of Traumatic Aneurysms—Dr. Robert M. Moore and (by invitation) Dr. J. C. Kennedy, Department of Surgery, University of Texas Medical Branch, Galveston.
Intrathoracic Ganglioneuroma, Case Report—Dr. George W. Waldron, Houston.

Drs. C. C. Green (chairman), George W. Waldron, and Herman Dustin composed the local arrangements committee.

TUBERCULOSIS SANATORIUM COURSE RESUMED

The State Tuberculosis Sanatorium at Sanatorium presented a postgraduate course in chest diseases for Texas physicians September 30-October 5, thus resuming an annual project which was discontinued during the war years but which has reached more than 100 physicians since its establishment in 1936. The first postwar course was attended by Drs. E. A. Johnson, Waco; M. L. Fuller, Cameron; Ray Cockrell, Snyder; R. R. Shaw, Dallas; and C. C. Bullard, H. M. Anderson, W. D. Anderson, and G. F. Madding, all of San Angelo. The Sanatorium provided quarters for the visiting physicians in a guest cottage.

Lectures were given by members of the Sanatorium medical staff and by Dr. Madding, surgeon and staff member, Shannon West Texas Memorial Hospital, San Angelo. The following program was carried out:

September 30

Welcome Address—Dr. J. B. McKnight, Superintendent.
Fluoroscopic Examinations.
Artificial Pneumothorax Refills.
Indications for Artificial Pneumothorax—Dr. R. C. Bernard.
Contraindications for Artificial Pneumothorax—Dr. Jack Pruitt.
X-Ray Interpretations.
Tuberculin Testing.

October 1

Aspiration of Pleural Fluids.
Effusion and Empyema—Dr. C. A. Slaughter.
Bronchogenic Carcinoma—Dr. Ray G. Boster, Jr.
Physical Examinations.

October 2

Fluoroscopic Examinations.
Artificial Pneumothorax Refills.
Adult Tuberculosis—Dr. W. W. Coulter, Jr.
Childhood Tuberculosis—Dr. Luther N. Hull, Jr.
Tuberculin Testing.

October 3

Intrapleural Pneumonolysis: Clinic.
Intrapleural Pneumonolysis with X-Ray Presentations—Dr. H. C. Samuel, Assistant Superintendent.
X-Ray Interpretations.
Physical Examinations.

October 4

Fluoroscopic Examinations.
Lipiodol Injections.
Bronchiectasis—Dr. Jesse L. Coleman.
X-Ray Interpretations.
Physical Examinations.

October 5

Intrapleural Pneumonolysis: Clinic.
Major Surgical Procedures in Tuberculosis—Dr. G. F. Madding, San Angelo.

WAR DEPARTMENT MEDICAL FILMS AVAILABLE THROUGH LIBRARY

Professional medical films which are the property of the Medical Department of the U. S. Army are now available for loan through the Motion Picture Film Library of the State Medical Association. Requests for the films described in this announcement should be made to the Library, 1404 W. El Paso Street, Fort Worth 3.

Requests for the Army films are subject to the following regulations:

Regulations for Borrowing Films

1. The film will be shown only to members of the medical profession or allied scientific groups who are bound by professional ethics.

2. No admission fee of any sort will be charged for the viewing of the films, and no reproductions of the film in whole or in part will be made.
3. The film will be shown only to the group and for the purpose indicated on this request.
4. Suitable projection equipment and the services of a competent motion picture operator will be provided by the borrower, and the War Department will not be called upon to furnish these facilities.
5. Cost of shipment of the film will be defrayed by the borrower.
6. The borrower will reimburse the Government for such damage to the film, while in his possession, as may necessitate the replacement of the print or any part thereof.
7. Film will be returned the day after the last showing for which borrowed.

Notes to Projectionist

1. All War Department films, unless specifically indicated to the contrary, are 16 mm., *sound films*, and must be projected on *sound equipment* only.
2. Return films on the reels and in the containers supplied with them.
3. If the film is damaged, do not make any repairs, but place a notation of the damage inside the film can and report the damage in writing to the lending agency.

Information Requested by Surgeon General

Date:
Name (Type or print):
Agency:
Address:
Film desired: Number: Title:
Purpose for which desired:
Group to whom film will be shown:
Date desired:
Schedule of showings:
Signature.....

By agreement with the office of the Surgeon General, the Library of the State Medical Association of Texas will forward a request for any member of the Association who wishes to borrow any of the films listed below, provided in making the request to the Library of the State Medical Association, the borrower states that he is agreeable and will comply with all required provisions as stated here. The borrower's request must include all the information called for in connection with each loan.

It is important that requests for loans of any of the films of the War Department be made well in advance of their showing, since the application must be made by the Library of the Association in duplicate directly to the Education and Training Division, Office of the Surgeon General, Washington, D. C. When approved, order for shipping the film must then go to the nearest Signal Corps Film Library, which library in turn will ship the film to the borrower.

After the film is shown, it must be returned to the Signal Corps Film Library from which it was obtained as indicated in the provisions previously stated.

A list of films available under the conditions set out above follows:

WAR DEPARTMENT MEDICAL FILMS

MISC 1233. **Neurosurgery in an Overseas General Hospital.** 16 mm., color, sound, showing time, 47 minutes. A record of typical neurosurgical problems encountered in overseas specialty centers. It is a film of primary interest to professional persons, since it presents the various technical phases required for acceptable diagnosis, treatment, and postoperative care.

MISC 1234. **Convalescent Care and Rehabilitation of Patients with Injury to Spinal Cord.** 16 mm., color, sound, showing time, 41 minutes. Approved diagnostic, surgical, nursing, and physical medicine technique and practices pertinent to the care and rehabilitation of paraplegic patients are pictured.

MISC 1236. **Thoracic Surgery, Part I—Hemothorax with a Consideration of Specific Remedial Breathing Exercises.** 16 mm., color, sound, showing time, 40 minutes. A presentation of the pathologic, diagnostic, and therapeutic aspects of hemothorax and other disorders of the pleura and the pleural cavity.

MISC 1237. **Thoracic Surgery, Part II—Foreign Bodies in the Lung and Mediastinum.** 16 mm., color, sound, showing time, 37 minutes. A picture of technical interest depicting the problems associated with the diagnosis, surgical planning, surgery, and postoperative care of patients who are found to have foreign bodies in the lung and mediastinum.

MISC 1238. **Thoracic Surgery, Part III—Foreign Bodies in the Pericardium and Heart.** 16 mm., color, sound, showing time, 50 minutes. A technical film covering the diagnostic planning, surgical, and postoperative technique considered essential to the proper handling of patients who possess a foreign body within the heart or pericardium.

MISC 1243. **Removal of Magnetic Foreign Bodies from the Eye.** 16 mm., color, silent, showing time, 18 minutes. Acceptible technique for the removal of magnetic foreign bodies from the eye and the handling of a detached retina case are portrayed for the benefit of a professional audience.

MISC 1244. **Removal of Intrathoracic Magnetic Foreign Bodies.** 16 mm., color, silent, showing time 20 minutes. Typical cases and the therapeutic measures utilized in each instance are pictured. It is a film of interest primarily to a professional audience.

MISC 1245. **Repair of Ruptured Membranous Urethra.** 16 mm., color, silent, showing time, 10 minutes. A technical presentation of an accepted surgical therapeutic measure for the management of a patient suffering from a ruptured membranous urethra.

MISC 1246. **Plastic Repair of Thigh Stump.** 16 mm., color, silent, showing time, 10 minutes. Portrays a type of plastic repair utilized on occasion where certain anatomical factors of the stump limit the operator's choice.

MISC 1249. **The Sky Is the Limit.** 16 mm., color, sound, showing time, 20 minutes. A picture of the phases of rehabilitation that apply to an above-knee amputee. It portrays the proper walking technique for persons with two normal lower extremities and for a unilateral AK amputee, and it emphasizes many of the capabilities which are within the reach of the patient who possesses the will to strive for them.

MISC 1271. **Below Knee Amputation.** 16 mm., color, sound, showing time 14 minutes. An accepted amputation method useful both immediately after injury and in the secondary repair of a stump is portrayed primarily for members of the medical profession and allied technically-trained personnel.

MISC 1272. **Radical Orchidectomy.** 16 mm., color, sound, showing time, 15 minutes. A technical film of interest to a professional audience. It shows an approved technique for the surgical removal of the testicle, an operation frequently encountered in peacetime, either following an injury or for removal of a malignancy.

MISC 947. **Amputation of the Lower Extremities.** 16 mm., color, silent, showing time, 44 minutes. This picture deals in a detailed manner with the amputation of the lower extremities indicating operative and postoperative procedure.

MISC 1081. **Reconditioning in the E. T. O.** 16 mm., sound, showing time, 29 minutes. This film

covers the phases of physical and occupational reconditioning as practiced in the E. T. O.

MISC 1197. **Combat Exhaustion.** 16 mm., sound, showing time, 50 minutes. Covers various phases of treatment of neuropsychiatric disorders in the theater of operations.

MISC 1241. **Let There Be Light.** 16 mm., sound, showing time, 60 minutes. This film deals with the methods of neuropsychiatric treatment in a general hospital, continental United States, using narcosynthesis, hypnosis, and group psychotherapy. It is restricted for showing to professional groups only.

FB 146. **Medical Service in the Invasion of Normandy.** 16 mm., sound, showing time, 15 minutes Shows the history of the planning and the action of the Medical Department in the first four days of the Normandy Invasion.

FB 147. **Medical Service in the Jungle.** 16 mm., sound, showing time, 20 minutes. Illustrates medical chain of evacuation under jungle conditions and field sanitation, malaria, and so forth.

FB 172. **Field Hospital.** 16 mm., sound, showing time, 13 minutes. This film illustrates graphically how a field hospital functions under combat conditions.

FB 173. **Evacuation Hospital.** 16 mm., sound, showing time, 10 minutes. Shows the operation and function of the evacuation hospital in the theater of operations.

FB 176. **Blood Bank in Natousa.** 16 mm., sound, showing time, 21 minutes. Describes the procuring, storing, and delivering of blood for battle casualties, technique of preparation of various items of equipment used, and combat scenes showing blood being delivered to assault units.

FB 180. **Trench Foot.** 16 mm., sound, showing time, 14 minutes. This film is a powerful direct story of trench foot, which effectively stimulates proper care of the feet.

FB 184. **Psychiatric Procedures in Combat Areas.** 16 mm., sound, showing time, 45 minutes. This film shows how the mild and moderately severe cases of combat exhaustion are handled in the division and Army areas.

FB 195. **D. D. T.—Weapon Against Disease.** 16 mm., sound, showing time, 13 minutes. Shows the extent of the insect borne disease problem and the history of the development of D. D. T.

FB 203. **General Hospital.** 16 mm., sound, showing time, 11 minutes. Shows the set-up, organization, and function of a general hospital in the theater of operations.

FB 132. **Evacuation of the Wounded.** 16 mm., sound, showing time, 16 minutes. Shows the echelons of medical service from injury on battlefield until return to the United States.

TF 8-2080. **Plaster Casts.** 16 mm., sound, showing time, 37 minutes. Shows all steps in the preparation of plaster casts, emphasizing the importance of the plaster technician's duties.

TF 8-1180. **First Aid for Chemical Casualties.** 16 mm., sound, showing time, 24 minutes. Shows complete details of first aid procedures for various gases, and the importance of the gas mask for individual protection against chemical gases.

TF 8-1467. **Control of Louse Borne Diseases.** 16 mm., sound, showing time, 13 minutes. Shows the control of louse borne diseases through personal and barrack sanitation, and the use of D. D. T. and other insecticides.

TF 8-2047. **First Aid for Battle Injuries.** 16 mm., sound, showing time, 27 minutes. Shows first aid for the soldier under simulated difficult battle conditions.

TF 8-2049. **First Aid for Non-Battle Injuries.** 16 mm., sound, showing time, 29 minutes. Covers first aid for common injuries such as burns, fractures, hemorrhage, and so forth.

DALLAS SOUTHERN CLINICAL SOCIETY COURSES

The Dallas Southern Clinical Society will offer postgraduate courses for the continuation of medical study in the fields of medicine, surgery, obstetrics, and pediatrics November 18-21 in Dallas. In the fall of 1940, the society offered the first of a planned series of quarterly postgraduate training periods, but the project was interrupted by the war and is only now being resumed.

The courses, under the direction of the society's Council for the Continuation of Medical Study, will be presented with the coöperation of the faculty of Southwestern Medical College and the staffs of the hospitals and clinics of Dallas. They are planned to cover the subjects intensively, utilizing lectures, clinics, and bedside teaching and demonstrations as applicable, and will give opportunity for intimate contact between instructors and registrants. Each course will be a separate entity and a registrant may attend only one course, but two joint sessions will be conducted at dinner. Any doctor of medicine who is a member of his county medical society is eligible to register, but each course is limited to twenty and registration must be made in advance. The fee for each course is $20 and should be sent with the application to the Executive Secretary, 433 Medical Arts Building, Dallas 1.

The November series will specialize in the following subjects: advances in therapy (medicine); surgery of the gastro-intestinal tract (surgery); normal and abnormal labor (obstetrics); and cardiorespiratory diseases (pediatrics).

A. M. A. SCIENTIFIC EXHIBITS SOLICITED

Application blanks for space to display scientific exhibits at the centennial session of the American Medical Association in Atlantic City, June 9-13, 1947, may be obtained now from the Director, Scientific Exhibit, American Medical Association, 535 North Dearborn Street, Chicago 10. Applications to furnish exhibits depicting the history of medicine during the past century and the latest developments of medical science must be filled out on regulation forms and submitted prior to January 13, 1947. The committee on scientific exhibits will then make its decisions and notify applicants.

LIBRARY NOTES

The package library consists of collections of reprints and other periodical material on various subjects, prepared for lending to members of the Association. Requests for packages should be addressed "Library, State Medical Association of Texas, 1404 W. El Paso Street, Fort Worth 3, Texas." Twenty-five cents in stamps should be enclosed with the request to cover postage and part of the expense of collecting the material. Only one package may be borrowed at a time, and packages are allowed to remain in the hands of the borrower for 14 days.

PACKAGE SERVICE

Packages were mailed from the Library of the State Medical Association during October, to the following:

Dr. Elliott Mendenhall, Dallas—*Medicine, socialized* (4 articles); *Tuberculosis, prevention and control* (15 articles).

Dr. V. D. Goodall, Clifton—*Breast, cancer* (7 articles); *Abdomen, surgery* (12 articles).

Dr. Paul H. Wedin, Houston—*Paralysis, spastic* (12 articles).

Dr. Masters H. Moore, Dallas—*Diarrhea, in infants and children* (21 articles).

Dr. J. P. Lovett, Olney—*Blood, groups* (14 articles).

Dr. Lilburn E. Standifer, Lamesa—*Arsenic, toxicity* (2 articles).

Capt. J. P. Gibson, Whipple, Ariz.—*Diabetes Mellitus, insulin in* (5 articles).

Dr. Oscar Huff, Pampa—*Fistula, anal* (10 articles).

Dr. J. S. Scarborough, Rusk—*Neurosyphilis* (24 articles): *Syphilis, penicillin in* (8 articles).

Library, Providence Hospital, Waco—*Hydrocele* (12 articles); (J. Bone & Joint Surg., April, 1937); *Poliomyelitis* (10 articles).

Dr. J. W. Neely, Pecos—*Poliomyelitis, therapy* (3 articles).

Dr. A. B. Goldston, Amarillo—*Thrombophlebitis* (14 articles).

Dr. W. R. Swanson, Taylor—(2 journals).

Mrs. Marvin L. Sharp, Vernon—(1 journal).

Dr. Charles Mims, Mission—*Menstruation, disorders* (18 articles); *Arthritis, therapy* (13 articles); *Posture* (15 articles).

Dr. Herbert E. Hipps, Waco—*Bones, tuberculosis* (16 articles).

Dr. W. A. Lee, Denison—*Anemia, in pregnancy and puerperium* (14 articles).

Dr. F. T. McIntire, San Angelo—(6 journals).

Dr. Maurice Barnes, Waco—(2 books).

Dr. R. B. McBride, Dallas—(2 journals).

Dr. C. B. Young, Tyler—*Respiratory Tract, diseases* (12 articles).

Dr. Howard O. Smith, Marlin—*Peptic Ulcer, surgical therapy* (6 articles).

Dr. C. C. Cogburn, Nixon—*Blood, groups* (10 articles).

Dr. Ross Owens, San Antonio—*Syphilis, therapy* (13 articles).

Dr. W. R. Snow, Abilene—*Granuloma, inguinale* (10 articles).

Dr. Roland F. Knox, Wichita Falls—*Parathyroid, diseases* (9 articles).

Mr. Bruce Roach, Austin—*Medicine, socialized* (4 articles).

Dr. L. C. Feener, El Paso—(1 journal).

Dr. Leta N. Boswell, Canyon—*Kidneys, calculi* (13 articles).

Dr. Jack Pruitt, Sanatorium—*Adhesions, abdominal* (6 articles).

Dr. Gordon F. Madding, San Angelo—*Lungs, surgery* (11 articles).

Dr. Wayne V. Ramsey, Abilene—*Cancer* (15 articles).

Dr. O. F. Harzke, Comfort—*Myasthenia, gravis* (12 articles); *DFP* (2 articles).

Drs. Standefer & Canon, Lubbock—*Vitreous, transplantation* (1 article).

Dr. George M. Tulloch, Okmulgee, Okla.—(24 journals).

Dr. E. M. Longoria, Laredo—*Penicillin, therapy* (7 articles).

Dr. Ray G. Boster, Sanatorium—*Tuberculosis, pulmonary* (8 artcles).

Mrs. Garrett Harrell, Hermleigh—*Music in Medicine* (4 articles).

Dr. Tate Miller, Dallas—*Sprue* (9 articles).

Dr. C. I. Shult, Columbus—*Demerol* (8 articles).

Dr. M. C. Carlisle, Waco—*Medical Economics* (1 article).

Dr. John D. Gleckler, Denison—(J. A. M. A., March 3, 1934); *Trichomoniasis* (9 articles); (McLester: Nutrition and Diet).

Dr. R. A. Neblett, Canyon—*Menopause, disorders* (14 articles).

Drs. Lamm & Lamm, La Feria—*Carotid Sinus* (13 articles).

Dr. B. H. Denman, Lufkin—*Blood, groups* (14 articles).

Dr. C. H. Frank, Texarkana—*Anesthesia, barbital* (4 articles).

Dr. J. E. Loveless, Slaton—*Medicine, socialized* (5 articles).

Dr. W. E. McRee, Port Arthur—(1 journal).

Dr. W. R. Sneed, Corsicana—*Curare* (14 articles).

Dr. J. T. Darwin, Decatur—*Heart, electrocardiography* (14 articles).

Dr. W. A. Potter, Amarillo—*Uterus, tumors* (11 articles).

Dr. Jim Camp, Pecos—*Leukocytes* (18 articles).

Dr. J. H. Wade, Lufkin—*Varicose Veins, therapy* (11 articles).

Dr. Lois L. Norman, Sherman—*Public Health, education* (12 articles).

ACCESSIONS

Chicago, Year Book Publishers—Rigler: The Chest, A Handbook of Roentgen Diagnosis.

Philadelphia, Blakiston Company—Meredith: Hygiene.

New York, The Dial Press—Berg: The Challenge of Polio.

Springfield, Charles C. Thomas—Fulton: Harvey Cushing, A Biograpphy; Snow: Principles in Roentgen Study of the Chest.

Philadelphia, J. B. Lippincott Company—Fishbein, editor: Medical Uses of Soap.

New York, Henry Schuman—Fulton and Stanton: The Centennial of Surgical Anesthesia; Robinson: Victory Over Pain, A History of Anesthesia; Morton: New Use of Sulphuric Ether, 1847.

SUMMARY

REPRINTS RECEIVED, 1,192	LOCAL USERS, 36
JOURNALS RECEIVED, 202	BORROWERS BY MAIL, 61
ITEMS CONSULTED, 113	PACKAGES MAILED, 71
ITEMS TAKEN OUT, 152	ITEMS MAILED, 638

TOTAL ITEMS CONSULTED AND MAILED, 905

MOTION PICTURE FILM LIBRARY

Motion picture films on medical subjects, 16 mm., both silent and sound, some in color, and suitable for either medical or lay audiences, are available for loan to county medical societies, hospital staffs, or individual physicians, on request. Borrowers will be required to pay only the cost of shipment of the films, by express, with insurance, and for any damage to films while in the hands of the borrower.

Requests for films should be addressed to "Motion Picture Film Library, State Medical Association of Texas, 1404 West El Paso Street, Fort Worth 3, Texas." A list of available films, with descriptions, will be furnished on request.

The following motion picture films were loaned by the Film Library of the State Medical Association of Texas during October:

Accent on Use (Available through the courtesy of the National Foundation for Infantile Paralysis)—West Texas Hospital Staff, Lubbock.

Antitoxins, Globulin Modified (Available through the courtesy of Lederle Laboratories, Inc.)—Harris School of Nursing, Fort Worth.

Appraisal of the Newborn (Available through the courtesy of Mead Johnson & Company)—Nolan-Fisher-Mitchell Counties Medical Society, Sweetwater.

Breech Extraction (Available through the courtesy of Mead Johnson & Company)—Nolan-Fisher-Mitchell Counties Medical Society, Sweetwater.

Know for Sure (Available through the courtesy of the Texas State Board of Health)—Foodhandlers' Sanitation School, Health Department, Fort Worth.

Poliomyelitis, Sister Kenny Method of Treatment of (Available through the courtesy of Dr. Herbert Hipps, Waco)—West Texas Hospital Staff, Lubbock.

When Bobby Goes to School (Available through the courtesy of Mead Johnson & Company)—Mixed lay group, Fredericksburg.

NEWS

Contributions to this department will be appreciated. News should be of general medical interest, such as public health activities, new hospitals, personal items of more than local value, etc. News for a particular number of the JOURNAL should be in the hands of the Editor not later than the fifteenth of the preceding month.

Meetings of National Societies Announced.—Notices have been received of various national meetings called for the next several months, which are listed below:

American Academy of Allergy, November 25-27, 1946.—The annual convention sessions, to be held at Hotel Pennsylvania, New York, will be open without payment of registration fee to all physicians interested in allergic problems, as guests of the academy. Latest methods of diagnosis and treatment and the results of investigation and research will be covered.

American Academy of Dermatology and Syphilology, December 7-12, 1946.—The fifth annual meeting, the first since 1941, will be held in Cleveland, with special lectures, symposia, and courses designed as a sort of "postgraduate seminar," and extensve scientific and commercial exhibits. Dr. Everett C. Fox, Dallas, is vice-president of the academy.

Gastric Cancer Conference, December 5-6, 1946.—The Gastric Cancer Committee of the National Advisory Cancer Council has arranged a third large conference which will be held at the Billings Hospital, University of Chicago, Chicago. Special stress will be placed on cancer of the gastro-intestinal tract.

Medical Education and Licensure, February 10-11, 1947.—The forty-third annual congress has been called by the American Medical Association's Council on Medical Education and Hospitals for the Palmer House, Chicago. Reservations should be sent to Frank Anton, office of the Council's secretary, 535 North Dearborn Street, Chicago 10.

American College of Physicians, April 28-May 2, 1947.—The twenty-eighth annual session will be held in Chicago, with Dr. David P. Barr, New York, president, in charge of the program of general sessions and lectures; Dr. LeRoy H. Sloan, Chicago, in charge of the program of hospital clinics and panels, local arrangements, and entertainment; and Edward R. Loveland, executive secretary, Philadelphia, in charge of general management and technical exhibits.

Congress on Obstetrics and Gynecology, September 8-12, 1947.—The third American congress will convene in the Municipal Auditorium, St. Louis. The program, under the direction of Dr. William F. Mengert, Dallas, is being planned to appeal to the obstetric and gynecologic specialist, the general practitioner interested in those fields, the hospital administrator, and nurses. Scientific exhibits, motion pictures, and technical exhibits will be presented. One session will be devoted entirely to the National Federation of Obstetric-Gynecologic Societies.

Phi Chi Lectureships for the fall have been announced by Dr. John Roberts Phillips, Houston, chairman of the arrangement committee. Dr. Chapman Reynolds, professor of pharmacology at Louisiana State University, New Orleans, will speak on "Medical Ethics" in Dallas on November 18, Houston on November 19, and Galveston on November 21. Dr. A. C. Broders, Mayo Clinic, Rochester, Minn., will lecture on "The Practice of Modern Surgery or Biopathology" in Dallas on December 9, Houston on December 10, and Galveston on December 16.

The Phi Chi medical fraternities at Dallas, Houston, and Galveston prorate the expense of these lectureships, but every practicing physician is invited to hear the speakers. In addition to the lecture courses for the advancement of medical education, Phi Chi provides loan funds for needy medical students, awards and scholarships for medical research, and maintains supplemental medical libraries.

The International Postgraduate Medical Assembly of Southwest Texas will hold its first assembly meeting since the war, January 29-31, 1947, in the San Antonio Municipal Auditorium. Dr. A. Fletcher Clark, San Antonio, is president of the assembly. In addition to lectures by distinguished physicians, there will be scientific and technical exhibits and motion pictures.

Guest speakers announced for the assembly include:

Dr. Howard K. Gray, Chief of Surgical Section, Mayo Clinic, Rochester, Minn.

Dr. Owen H. Wangensteen, Chief of Department of Surgery, University of Minnesota Medical School, Minneapolis.

Dr. Shields Warren, Pathologist, New England Deaconess Hospital, Boston.

Dr. Henry G. Poncher, Professor and Head of Department of Pediatrics, University of Illinois College of Medicine, Chicago.

Dr. Fred Wise, New York.

Dr. Edward H. Rynearson, Clinical Section, Mayo Clinic, Rochester, Minn.

Dr. William E. Gallie, Professor of Surgery, Banting Institute, Toronto, Canada.

Dr. Austin I. Dodson, Attending Urologist, St. Elizabeth's Hospital, Richmond, Va.

Dr. M. A. Blankenhorn, Director of Department of Internal Medicine, Cincinnati General Hospital, University of Cincinnati College of Medicine, Cincinnati.

Dr. Demetrio Sodi Pallares, National Institute of Cardiology, Mexico, D. F.

Dr. Francis E. LeJeune, New Orleans, La.

Dr. John McLean, Cornell University Medical School, New York.

Dr. Willard R. Cooke, Professor of Obstetrics and Gynecology, University of Texas Medical Branch, Galveston.

Cardiologists Organize Internationally.—Cardiologists from throughout the world attended the first International and the second Inter-American Cardiological Congress in Mexico, D. F., October 6-12 to hear speakers from both hemispheres and to organize an international council. Plans were made for a meeting in 1948 at Chicago, and one in 1950 at Paris.

Among the two hundred participants in the Congress were Drs. George R. Herrmann, Galveston; J. D. Landesman, Corpus Christi; W. B. Adamson, Abilene; and Joseph Kopecky, Herbert Hill, and W. W. Bondurant, San Antonio, Dr. Herrmann, who served as alternate delegate of the American Heart Association, presented a paper describing his work on arteriosclerosis and was elected director and secretary of the board of five Anglo-American and five Latin-American directors. An international cardiological council headed by Dr. Charles Laubry, Paris, was also established.

Dallas Health Museum.—According to figures released by the Dallas Health Museum, 2,700 persons visited the museum on its opening day, October 5. The museum, which was organized September 17, was rushed into shape so that exhibits would be ready for showing during the State Fair of Texas, and many visitors to the Fair took advantage of the opportunity to see graphic demonstrations of how human beings are constructed, how they grow, and how they may keep healthy.

Dr. Bruno Gebhard, director of the Cleveland Health Museum, made the main talk at opening exercises of the museum October 5 and made available some exhibits from the Cleveland museum for display during the Fair. The Mayo Foundation, Rochester, Minn.; the American Medical Association, Chicago; and Scott and White Clinic, Temple, also loaned special displays for the opening weeks of the museum and sent representatives to participate in early functions of the museum. One outstanding exhibit which has been purchased by the museum for its permanent use is a series of three dimensional sculptures showing the development of the human embryo. A duplicate of the Dickinson-Belskie Collection of the Cleveland Health Museum, this exhibit is the only like collection available for public showing. Motion pictures dealing with health subjects were shown twice daily throughout the period of the Fair and will be shown frequently on a regular schedule now that the Fair has closed. Exhibits at the museum will be changed from time to time, and it is anticipated that a particular health subject will be emphasized each month, with special events and lectures arranged to carry out the theme.

No admission will be charged by the museum, which was launched by the Dallas Academy of Medicine. Those who wish to assist in the work of the museum, however, are being invited to join the Dallas Health Museum for $10 annually. Present members of the board of trustees include the following physicians: Drs. V. R. Hurst, Longview, and Wilfred J. Allison, H. R. Levy, Oscar M. Marchman, Sr., Everett C. Fox, Milford O. Rouse, J. W. Bass, Horace E. Duncan, and J. M. Pickard, Dallas, the latter three ex-officio.

Texas Child Health Council.—Dr. Arild E. Hansen, professor of pediatrics at the University of Texas School of Medicine, Galveston, and chairman of the University's Child Health Program, was renamed chairman of the Texas Child Health Council when it met in Dallas on September 22. Dr. T. J. McElhenney, Austin, was elected vice-chairman. Problems pertaining to the health of Texas children were discussed and special attention was given to postgraduate pediatric conferences scheduled for the fall. Dr. Edward Pratt of the Yale University Medical School, New Haven, Conn., and Dr. Paul Harper, Baltimore, were special guests at the meeting, which was also attended by representatives from the department of pediatrics of the three Texas medical schools, the Texas Pediatric Society, Texas section of the American Academy of Pediatrics, State Medical Association, State Board of Health, and University of Texas College of Dentistry, Houston.—*Galveston News.*

The San Antonio Medical Service Society held a banquet the latter part of September with Dr. V. C. Tucker, president of the Bexar County Medical Society, and Dr. Howard Bush, president of the Bexar County Library Association, as guests, informs the San Antonio *Express.* Plans were formulated to assist in raising funds for the Bexar County Medical Society Library.

Ennis Physicians Were Honored on October 10 when the Lions Club paid tribute to the doctors for their outstanding service during World War II, states the Ennis *Weekly Local.* Following a talk by Judge A. R. Stout praising the unselfish service of the physicians, Congressional Medals of Service were presented to Drs. Fred L. Story, A. L. Thomas, E. F. Baker, John M. Chapman, and to Mrs. L. E. Clark posthumously for the late Dr. Clark for their contributions to the Selective Service program.

Tom Green County's Crippled Children's Clinic was held October 17 under the sponsorship of the Tom Green-Eight County Medical Society, County Health Board, and the local Crippled Children's Society, states the San Angelo *Standard-Times.* All persons desiring examinations were welcomed, and treatment approved by county officials will be paid for from federal and state funds. Invitations to participate in the clinic were sent to Drs. Frank Hodges, Abilene; Brandon Carroll, Paul C. Williams, and James T. Mills, Dallas; G. W. N. Eggers, Galveston; Walter G. Stuck and Charles W. Tennison, San Antonio.

Health Clinics are being conducted weekly for preschool children of Killeen, Hood Village, Copperas Cove, Nolanville, Maxdale, Youngsport, and the area between by Dr. F. Paul Burow, health officer of Killeen, the Killeen *Reporter* states. Similar clinics have been begun on a monthly schedule at Merkel, with Dr. David M. Cowgill, director of the Abilene-Taylor County Health Unit, in charge, informs the Merkel *Mail.*

Free immunization service was offered all students of the Monahans-Wickett school system October 10, according to the Monahans *News.* Drs. Otto Munk, Paul Kunstadt, D. L. Bell and F. J. Prout gave the vaccinations.

Morningside Heights, El Paso, will have a free clinic established by the City-County health unit, informs the El Paso *Herald-Post.* The clinic was requested by the Morningside Heights Civic Club, which will furnish and equip a room in the basement of one of the school buildings for the clinic.

Hidalgo County Tuberculosis Cases will be tracked down and treated in a long-range program now being mapped by the county health department in cooperation with the Hidalgo-Starr Counties Medical Society and the Hidalgo County Tuberculosis Association, according to the Mission *Times.* A mobile x-ray unit owned by the State Department of Health will be available to the county when nurses can be obtained to do follow-up work, Dr. Mary Walton, county health officer, says. It is hoped that the case-finding phase of the program will be started this winter. Requests are being made for space in Edinburg, McAllen, Weslaco, Mission, and perhaps Pharr and Edcouch-Elsa to use for clinics for the tuberculosis program and also for mother and child health centers. Lists are now being made of all tuberculosis cases reported in the county since 1940 and treatment of several hundred cases is being followed up. Children from junior high school age up and adults will be included in the x-ray unit case-finding program when it gets under way. Persons suspected of having tuberculosis will be directed to seek additional diagnosis by private physicians or at clinics, and persons financially able to do so will be expected to undergo treatment prescribed by their own physicians. No sanitarium is located near the Rio Grande Valley, although the area is known to have one of the highest tuberculosis rates in the United States. Efforts are being made by the State Board of Control to secure Fort Ringgold at Rio Grande City for a sanitarium, but it is hoped that the program designed to locate and treat cases of tuberculosis early in its course may be particularly useful.

Veteran Administration Hospitals in Texas, Louisiana, and Mississippi have received more than $7,000 worth of movie equipment especially designed for bedridden patients through the generosity of the Texas Variety Club, informs the Mansfield *News.* The club, whose members are Texans in the entertainment industry, donated twenty-two portable projectors which will throw movies on the ceiling or overhead screens and which are equipped with three headphone sets so that selected patients may listen to movie dialogue without disturbing others in the ward.

The Brooke Army Medical Center, Fort Sam Houston, graduated about forty medical officers from

the School of Military Neuropsychiatry in September, the Surgeon General reports. The twelve weeks course covered the basic principles and practices of both psychiatry and neurology with emphasis on methods adapted for Army use, and included clinical lectures and bedside work with patients at Brooke General Hospital. Through the Rockefeller Foundation outstanding specialists in neuropsychiatry were made available for visits to the school, among them Dr. Titus Harris, University of Texas Medical Branch, Galveston. This school was the first of its kind at Brooke, although a similar school has been conducted since 1942 at Atlanta, Ga., and at Brentwood, L. I., N. Y. Another class has been scheduled to start in November.

Another course completed at the Brooke Army Medical Center in September was for twenty-two selected faculty members from medical schools throughout the United States who were given a two weeks indoctrination course in Reserve Officer Training Corps duties in preparation for instructing R. O. T. C. classes at their respective institutions this year. Plans are being considered to install R.O.T.C. courses in several medical schools not already offering such training.

Civilian Consultants to the Secretary of War through the Surgeon General have been increased by an additional 111 physicians, surgeons, and psychiatrists, the War Department disclosed in September. A total of more than 200 consultants has now been named to help maintain the highest standards of medical practice in the Army. Texans listed in the latest announcement include Drs. David R. Sacks, San Antonio; Lester C. Feener, El Paso, internal medicine; John A. Hardy, El Paso, general surgery; Louis Breck, El Paso; David N. Cameron, El Paso, orthopedic surgery; Raleigh L. Davis, San Antonio; Wickliff R. Curtis, El Paso, urology; Charles W. Tennison, San Antonio; Truman G. Blocker, Jr., Galveston, plastic surgery; John W. Winter, San Antonio, anesthesiology; Francis A. Snidow, El Paso, obstetrics and gynecology; M. P. S. Spearman, El Paso, ear, nose, and throat.

Texas Medical Center.—Bids were opened October 21 for more than $200,000 worth of the $400,000 improvements scheduled for the Texas Medical Center area, the Houston *Chronicle* reveals. Included in the improvements which are to begin immediately are permanent paving of some of the main streets in the area and construction of storm and sanitary sewers and underground conduits and lines for utilities. It is expected that the first units of the proposed improvements will be completed in time for the opening of the Baylor University College of Medicine in its new building next spring.

The U. S. Naval Hospital became the first new medical institution to be completed in the Texas Medical Center when it was commissioned September 4, according to *The Journal of the American Medical Association.* The $9,000,000 hospital, consisting of thirty-seven buildings and containing 1,000 beds, will be a research center for plastic surgery and for the treatment of tropical diseases.

Erection of the fourteen story, $1,800,000 Hermann Professional Building was expected to begin immediately following approval in September by the Civilian Production Administration of the use of building materials provided they are not classed as critical for veterans' housing, reports the Houston *Post.*

University of Texas.—The Board of Regents of the University of Texas at its September meeting ordered full continuance without change of current operations at the Medical Branch in Galveston pending appeal to the Legislature for an adjustment of funds in the budget adopted in 1944 before prices and labor costs advanced so appreciably, the Galveston *Tribune* indicates.

Formal dedication of the thirty bed Stewart Convalescent Home was held October 30, according to the Galveston *Tribune.* Mr. Maco Stewart, who donated the residence to the Department of Pediatrics of the University in 1944, participated in the luncheon ceremony at the home. Dr. Elizabeth Knott, resident administrator, and Dr. Arild E. Hansen, chairman of the Child Health Program and professor of pediatrics, were honor guests.

A premature baby unit has been established at the Children's Hospital to reduce the mortality in infants and to serve as a teaching unit for University students and pediatricians taking postgraduate study, the Galveston *News* informs. Dr. Arild E. Hansen, director of the Child Health Program, points out that the unit is rather small and does not meet the present needs for premature babies.

A new course dealing with the applications of physics to physiology and medicine has been inaugurated at the University of Texas School of Medicine by the Departments of Physiology and Radiology. The course is designed as an orientation course for first year students.

The Southwest Section of the Society for Experimental Biology and Medicine met at the University of Texas Medical Branch on October 26, states the Galveston *Tribune.* The Southwest Section was organized three years ago at the University.

A delegation of students from the University of Puebla Medical School in Mexico visited Galveston in September and were impressed with the facilities of the University of Texas School of Medicine and the hospitality of its staff, reveals the Galveston *News.*

The Medical Dames, an organization of the wives of students at the University of Texas School of Medicine, held a style review at the Rebecca Sealy Nurses Home on October 16, the Galveston *Tribune* reports. Twenty-three new members were added with the beginning of the fall semester.

Howard G. Swann, Ph. D., assistant professor of physiology, has received a grant of $10,000 from the Army Research Program for studies in aviation physiology begun by Dr. Swann during the war at Wright Field. Dr. R. M. Brucer, formerly lieutenant colonel in the Medical Corps of the Airborne Troop Service, has been appointed instructor in physiology and will continue his research in aviation physiology in coöperation with Dr. Swann, according to the Galveston *Tribune.*

Dr. Robert William Davis, formerly assistant professor of psychiatry at the University of Colorado School of Medicine, Denver, has accepted a position as assistant professor of neuropsychiatry at the University of Texas and assistant director of the State Psychopathic Hospital, the Galveston *Tribune* informs.

Dr. Truman G. Blocker, Jr., associate professor of surgery at the University of Texas School of Medicine before he joined the Army to specialize in plastic surgery during World War II, is back at the University as professor of plastic and maxillofacial surgery, the Galveston *News* reports. The Department of Plastic Surgery is being organized as a specialty and will also include a dental surgeon and a speech expert for children afflicted with hairlips and cleft palates. Research will be carried on in wound healing and the prevention of scarring.

Dr. George M. Decherd, Jr., professor of internal medicine at the University of Texas School of Medicine and director of the heart station in the outpatient building, has been named director of the Student Health Service at the Main Branch in Austin, states the Galveston *News.* A new hospital-clinic building is to be erected in the near future according to plans of the Board of Regents. Dr. Decherd will retain a connection with the Medical Branch as visiting professor of internal medicine

and will continue his research program in cardiology at Galveston.

Dr. Henry H. Sweets, associate professor of pathology, has resigned to accept a position at the University of Kentucky, and Dr. A. N. Taylor, assistant professor of physiology, has resigned to go to the University of Oklahoma, reports the Galveston *Tribune*.

Chauncey D. Leake, Ph. D., vice-president and dean of the University of Texas School of Medicine, will speak on the centennial of ether anesthesia at a joint meeting of the Institute of Medicine and the Society of Medical Historians in Chicago on November 22, according to *The Journal of the American Medical Association*.

D. Bailey Calvin, Ph. D., associate dean of the School of Medicine, discussed "Recent Advances in Medicine and Their Effect on Premedical Needs" before the Association of American Medical Colleges at Edgewater Park, Miss., October 28-30, *The Journal of the American Medical Association* informs..

Personals

Dr. W. B. Reeves, Greenville, has retired from general practice and will limit his activities to consultations, anesthetics, and railway and insurance practice, states the Greenville *Banner*.

Dr. W. H. Beazley, Silsbee, recently returned from the first vacation he has had in thirty-four years of active practice, is limiting his practice to work in his clinic and to consultations, reports the Silsbee *Bee*.

Dr. Clay Lauderdale, Buda physician since 1911, has retired from practice and moved to his farm nearby, informs the Austin *American*.

Dr. and Mrs. Joe Gilbert, Austin, the first couple to be married in Galveston after the devastating 1900 storm, observed their forty-sixth wedding anniversary September 13, according to the Austin *American-Statesman*.

Dr. A. D. Patillo has assumed the superintendency of the State Hospital at Terrell succeeding *Dr. Roy C. Sloan*, who submitted his resignation to move to Lubbock, according to the Kaufman *Herald* and Terrell *Tribune*. Dr. Patillo, recently released from Army service, was previously with the state hospital at Wichita Falls.

Dr. Hugh C. Welsh, Houston, has been elected president of the St. Joseph's Infirmary staff, the Houston *Chronicle* states. *Dr. G. N. Cunningham* was named vice-president, and *Dr. Palmer Wigby*, secretary.

Dr. Garland S. Rushing, Longview, was reported by the Longview *Lens* in September to be carrying on his practice by taxicab after his automobile was stolen from his garage.

Dr. A. L. Dippel, Houston, has been invited by the Tulane Postgraduate Medical School, New Orleans, to be the guest speaker in obstetrics and gynecology for a course next January, informs *Medical Record and Annals*.

Dr. Ralph Bowen, Houston, has been named by the Charles G. Thomas Publishing Company as editor-in-chief of its new text, "Pediatric Allergy," which will be compiled with fifteen other allergists, according to *Medical Records and Annals*.

Dr. Allen T. Stewart, Lubbock, discussed one of the papers presented at a meeting of the Central Association of Obstetrics and Gynecology in Chicago in September and also represented Texas, Oklahoma, and Kansas at a joint committee meeting of leaders of the Farm Bureau and the Committee on Rural Medical Service of the American Medical Association, reports the Lubbock *Avalanche-Journal*.

Dr. F. Keith Bradford, Houston, presented a paper on "Hemangioblastoma of the Posterior Fossa" for the American Academy of Neurological Surgery in Hot Springs, Va., September 9-11, states *Medical Record and Annals*.

Drs. Michael K. O'Heeron and *B. Weems Turner*, Houston; *F. S. Schoonover, Jr.*, Fort Worth; and *R. E. Cone*, Galveston, participated on the program and committees of the South Central Section of the American Urological Association meeting in Hot Springs, Ark., September 30-October 2, according to the Houston *Post*, Fort Worth *Press*, and Galveston *News*.

Dr. James T. Mills, Dallas, was a special guest on the program of the American Academy of Ophthalmology and Otolaryngology in Chicago, October 13-18, according to *The Journal of the American Medical Association*. *Dr. John M. Robison*, Houston, presented a paper for the Pan American Congress on Otolaryngology and Broncho-Esophagology held October 18 in conjunction with the academy meeting.

Dr. Alvis E. Greer, Houston, will participate in an "Information Please in Medicine" at the meeting of the Southern Chapter, American College of Chest Physicians in Miami, Fla., November 4, *Medical Record and Annals* informs. Dr. Greer as chairman of the board of examiners for the college will help conduct examinations at the Florida meeting.

Dr. Carl A. Moyer, Dallas, spoke on "Some Effects of Anesthesia, Load and Comparison on the Excretion of Water and Salt" at the celebration in Boston on October 14-16 of the one hundredth anniversary of the first public demonstration of ether anesthesia, informs *The Journal of the American Medical Association*.

Marriages

Dr. Arthur C. Scott, Temple, married Miss Greneta Courtney in Temple on October 9.

SOCIETY NEWS

Colorado-Fayette Counties Society

September 24, 1946

(Reported by C. I. Shult, Secretary)

Diagnosis and Management of Several Surgical Conditions—J. R. Phillips, Houston.
Public Relations and Medical Economics—F. J. L. Blasingame, Wharton.

Colorado-Fayette Counties Medical Society met at Eagle Lake on September 24. J. R. Phillips, Houston, was presented as guest speaker in a discussion of the diagnosis and management of several surgical conditions. Two motion pictures, one on subtotal gastric resection and one on gallbladder surgery, were shown. F. J. L. Blasingame, Wharton, Councilor of the Eighth District, spoke on medical economics and public relations.

Dawson-Lynn-Terry-Gaines-Yoakum Counties Society

September 12, 1946

Hand Surgery—Urban H. Zee, Lamesa.
Hysterectomy—W. P. Pigford, Seminole.

Dawson-Lynn-Terry-Gaines-Yoakum Counties Medical Society met in Seminole on September 12. The program consisted of a talk on hand surgery by Urban H. Zee, Lamesa, and one by W. P. Pigford, Seminole, on hysterectomy.

Denton County Society

October 3, 1946

Denton County Medical Society, meeting October 3 in Denton, unanimously endorsed a $150,000 bond proposal for a city-county hospital to be voted on in a city bond election October 15 and made plans to support the proposal actively. The society also passed a resolution recommending that the board of

trustees of the Flow Memorial Hospital fund proceed with plans for the city-county hospital as rapidly as possible.

Plans for a hospital were begun several months ago after property valued at $150,000 was donated by Homer E. Flow toward the Flow Memorial Hospital fund. The board of trustees of the fund expects to secure contributions from the city and county and possibly other sources. The Denton city commission set the October date for a vote regarding the city's participation in the hospital project, the same date already having been set for a municipal bond election.

The medical society's president, William H. Magness, reported that members of the society had had considerable difficulty in securing sufficient hospital rooms for their patients and that they believed expansion of local hospital facilities is urgent.

M. L. Hutcheson and Walter B. Miller, Jr., were named to coöperate with local druggists in a campaign to urge voters to support the hospital measure.

El Paso County Society

October 8, 1946

Symposium: Amebiasis—William Beaumont General Hospital Staff Members.
- Amebiasis among Prisoners of War in the Philippine Islands—Major John K. Wallace.
- Laboratory Diagnosis—Capt. James L. Orbison.
- Sigmoidoscopic and Proctoscopic Diagnosis—Capt. Manuel White.
- X-Ray Diagnosis—Capt. Raymond J. Scheetz.
- Modern Drug Therapy—Col. Howard Hansen.
- Surgical Aspects—Capt. Walter W. Wollmann.

El Paso County Medical Society met with the William Beaumont General Hospital staff for dinner and a scientific program at the hospital. Six of the hospital physicians presented a symposium on amebiasis as outlined above.

Gregg County Society

September 10, 1946

(Reported by John E. Wensley, Secretary)

Urinary Diseases and Gastro-Intestinal Symptoms—Howard Shane, Dallas.
Intestinal Obstruction—Jack Peyton, Dallas.

Gregg County Medical Society met in the Hurst Clinic, Longview, on September 10 for the scientific program outlined above.

The need for local hospitals was discussed and a committee consisting of V. R. Hurst, Hardy Cook, and W. P. Farrar, Longview; Seth R. Downs and W. M. Routton, Kilgore; and J. C. Leake and R. B. Hancock, Gladewater, was appointed to investigate.

Charles T. Richardson, Kilgore, was reinstated to membership upon application.

John E. Wensley, Longview, was elected secretary to succeed George Tate, Longview, who resigned.

Jefferson County Society

August 12, 1946

(Reported by L. R. Byrd, Jr., Secretary)

The Board of Directors of the Jefferson County Medical Society held a called meeting at St. Mary's Hospital, Port Arthur, on August 12, with President George Sladczyk, Port Arthur, presiding.

Information from the National Physicians Committee regarding bills of a medical nature introduced into Congress and regarding prepayment medical insurance plans was discussed. It was unanimously agreed to devote the program time of the October meeting of the society to consideration of a report from the Economics Committee on prepayment medical insurance plans.

L. C. Powell, Beaumont, reported that upon invitation from the Beaumont Chamber of Commerce he had attended a meeting to establish a screening committee for passing on all campaigns for money in Beaumont. Decision had been made to request the medical society to appoint one of its members to serve on the proposed committee. President Sladczyk appointed Dr. Powell to represent the society.

In a general discussion of the venereal disease units of Beaumont and of the venereal disease education program, the consensus was that the Venereal Disease Committee had been empowered to proceed with plans for such a venereal disease education program as circumstances allow.

Dr. Powell moved that the secretary draw up a resolution for presentation at the September meeting of the society providing for amendment of the By-Laws of the society to employ an executive secretary. The motion was seconded by L. C. Heare, Port Arthur, and carried.

The board decided that the secretary should notify adjacent county medical societies of Jefferson County scientific programs and invite their members to attend.

There was a general discussion concerning election of a new district councilor at the 1947 annual session of the State Medical Association.

Dr. Powell moved, seconded by Dr. Heare, that the secretary write S. E. Thompson, Kerrville, expressing the appreciation of the society for his efforts toward passage of a "tenure of office" measure in the State Medical Association and for following to completion the appeal of a Jefferson County case to the American Medical Association. The motion carried.

Wallace Byrd, Beaumont, was accepted for membership by transfer from the Wharton-Jackson-Matagorda-Fort Bend Counties Medical Society.

September 9, 1946

(Reported by L. R. Byrd, Jr., Secretary)

Clinical-Pathological Conference—John R. Bevil, Beaumont, presiding.
- Presentation of Case—John R. Bevil, Beaumont.
- Discussion—D. A. Mann, Taylor Walker, E. C. Ferguson, J. C. Crager, H. H. Bevil, Beaumont.
- Pathologic Observations and Diagnoses—John R. Bevil, Beaumont.

Psychosomatic Concepts in General Practice—Perry C. Talkington, Dallas.
- Discussion—H. H. Bevil, Taylor Walker, and L. T. Pruit, Beaumont.

Jefferson County Medical Society met in regular session at St. Therese Hospital, Beaumont, on September 9, with President George Sladczyk, Port Arthur, presiding.

The scientific program noted above was presented under the general direction of W. Price Killingsworth, Port Arthur, program committee chairman.

The secretary, L. R. Byrd, Jr., Port Arthur, read a proposed amendment to the By-Laws providing for employment of an executive secretary to assist the secretary-treasurer in his duties. Such an executive secretary would be employed by the society under direction of the board of directors and supervision of the secretary-treasurer at a salary rate to be determined by the board of directors. He would not be empowered to disburse any funds of the society except from a petty cash fund to be maintained at $25, for which he would be accountable to the secretary-treasurer.

L. C. Powell, Beaumont, reported that B. E. Pickett, Carrizo Springs, President-Elect of the State Medical Association, had expressed a desire to visit Jefferson County Medical Society after October 20 and would like to have present at such a meeting representatives of all societies of the district. Dr. Powell recommended that Dr. Pickett be invited for the November meeting. After discussion the time of such a meeting was left for later determination.

L. C. Heare, Port Arthur, stated that he and Dr. Powell had recently been present at a meeting in Dallas held to establish a Texas committee of the National Physicians Committee. He suggested that a report of this meeting be given at the November meeting of the Society.

Lubbock-Crosby Counties Medical Society

September 3, 1946

(Reported by Martin H. Benson, Secretary)

Prophylaxis in Children, Primarily for Diphtheria—Arthur Jenkins, Lubbock.
Discussion—O. J. LaBarge, Lubbock.

Lubbock-Crosby Counties Medical Society met September 3 at the Plains Clinic, Lubbock, with approximately thirty in attendance. A. G. Barsh, Lubbock, president, presided.

Arthur Jenkins, Lubbock, discussed prophylaxis in children, speaking primarily of diphtheria. He gave a history of the disease; discussed seasonal variations, sex hygiene, pathology, and symptoms; pointed out the three common types, faucial, laryngeal, and nasal; and covered the routine prophylactic measures and active treatment for diphtheria. O. J. LaBarge, Lubbock, opened a general discussion by telling of a diphtheria epidemic in Germany during the war.

Martin H. Benson, Lubbock, secretary, reported a telephone conversation with H. H. Latson, Amarillo, Councilor of the Third District, regarding possible rearrangement of the district. Following a discussion of the proposed changes, Dr. Jenkins moved that a letter be sent to Dr. Latson expressing the satisfaction of the society with the present composition of the district and recommending that if any change is made it be to increase the size of the district. The motion was seconded by Sam C. Arnett, Jr., Lubbock, and carried unanimously.

A letter was read concerning hospital needs in the area. Allen T. Stewart, Lubbock, discussed pertinent points of the Hill-Burton bill and moved that a committee be appointed to study local hospital needs. The motion carried and Drs. Stewart, J. T. Hutchinson (Lubbock), and Arnett were appointed to the committee.

A letter concerning a fee schedule for the Veterans Administration was read and turned over to Olan Key, Lubbock, member of a fee schedule committee consisting of Drs. Hutchinson, Key, and Ewell L. Hunt, Lubbock.

The registration, arrangements, and entertainment committees reported on their activities in preparation for the forthcoming district meeting in Lubbock. Dr. Arnett, moved, seconded by Dr. Watkins, that the entertainment committee be limited to the expenditure of $500 for the meeting.

Applications for membership from L. E. Hale, W. H. Gordon, and F. W. Hudgins were unanimously approved.

October 1, 1946

(Reported by Martin H. Benson, Secretary)

Avertin Anesthesia—Fred W. Standefer, Lubbock.

Lubbock-Crosby Counties Medical Society met October 1 at the Plains Clinic, Lubbock, with thirty members present and President A. G. Barsh, Lubbock, presiding.

Fred W. Standefer, Lubbock, discussed avertin anesthesia, pointing out the changes in blood and body chemistry following the use of this type of anesthesia. He was of the opinion that it should be used as a basal anesthetic to be supplemented by inhalant anesthesia. The paper was discussed generally.

Chairmen of the arrangements, registration, and entertainment committees reported that plans were nearing completion for the district meeting in October.

Olan Key, Lubbock, reported for the fee schedules committee that business managers of various hospitals had been communicated with and a set of fees had been worked out.

Charles Ameen, Lubbock, was accepted unanimously for membership upon application.

Tarrant County Society

September 17, 1946

(Reported by W. P. Higgins, Jr., Secretary)

Some Observations on Skin Grafting (colored slides)—William M. Crawford, Fort Worth.
Discussion—T. H. Thomason and Thomas J. Cross, Fort Worth.

Tarrant County Medical Society met September 17 in the auditorium of the Medical Arts Building, Fort Worth, with twenty-nine members and four visitors present. May Owen, president-elect, presided in the absence of the president. The scientific program noted above was carried out.

James H. Benton, Leroy Bursey, William E. Flood, James K. Norman, and John H. Richards (intern) were elected to membership upon application.

Tribute was paid Dr. Henry Trigg, Fort Worth, who died September 12.

October 1, 1946

(Reported by W. P. Higgins, Jr., Secretary)

Medical Aspects of Glaucoma—Jack D. Brownfield, Fort Worth.
Discussion—W. H. McKenzie, A. E. Jackson, and J. W. Eschenbrenner, Fort Worth.
Relationship between the Work on Alcoholism and the Doctor—W. P. McLean, Fort Worth.

Tarrant County Medical Society met October 1 in the Medical Arts Auditorium, Fort Worth, with thirty-four members and five visitors present. W. B. West, Fort Worth, vice-president, presided. The program noted above was presented, with W. P. McLean, attorney, as guest speaker.

W. F. Ossenfort and William H. Morgan were elected to membership upon application.

Dr. J. H. McLean, Fort Worth, who died September 20, was paid tribute.

October 15, 1946

(Reported by W. P. Higgins, Jr., Secretary)

Tarrant County Medical Society met October 15 in the Medical Arts Auditorium, Fort Worth, with May Owen, Fort Worth, president-elect, presiding. Dr. Owen reminded members of the Thirteenth District meeting to be held at Graham on October 24.

X. R. Hyde, Fort Worth, commented on the booklet "Compulsion" regarding the hearings on the Wagner-Murray-Dingell bill and stated that it would be well for all physicians to read it. He also called attention to an article in *Medical Economics* concerning the C. I. O. and P. A. C.

Secretary Higgins reported that the Renfro Drug Company desired to have a dinner for the medical society and asked that the society agree upon a time. Tom Bond, Fort Worth, seconded by Frank G. Sanders, Fort Worth, moved that the matter be turned over to the entertainment committee. The motion carried.

Tom Green-Eight County Society

July 15, 1946

(Reported by W. Grady Mitchell, Chairman, Executive Board)

The executive board of Tom Green-Eight County Medical Society met July 15 following the meeting of the society at the home of R. M. Finks, San Angelo.

It was agreed that the following recommendations be submitted to the society: (1) That a committee be appointed by the chairman to study and revise the Constitution and By-Laws. (2) That a committee be appointed to study means to advance San Angelo as a medical center.

September 2, 1946

(Reported by R. M. Finks, Secretary)

Tom Green-Eight County Medical Society met at Hotel Cactus, San Angelo, on September 2 with twenty-four members and guests present. W. Grady Mitchell, San Angelo, president, presided.

Floyd T. McIntire, San Angelo, chairman of the

medical advisory committee of the local tuberculosis association, presented two motions for the society's approval. One motion provided that the society approve construction of a city-county hospital with facilities for low-income persons and wings for care of tuberculous, mental, maternity, and contagious patients, as well as for general modern hospital care. The other motion provided that efforts be made to interest prospective donors in the endowment of a modern tuberculosis hospital for private patients, to be operated as a part of an established general hospital. Victor E. Schulze, San Angelo, moved, seconded by J. Frank Jones, San Angelo, that the recommendations be approved. The motion carried.

Following a general discussion regarding a city-county hospital and staffing such a hospital, Dr. McIntire moved that the society endorse establishment of a city-county hospital. The motion carried unanimously.

Dr. McIntire, vice-president, took the chair while Dr. Mitchell presented a report from the executive board meeting of July 15. Dr. Mitchell moved that a committee be appointed to study and revise the Constitution and By-Laws, and to advance San Angelo as a medical center. The motion carried, and Drs. Schulze, Perry, J. C. Byars, McIntire, Kyle B. Round, and George L. Nesrsta, all of San Angelo, were appointed to consider both problems.

George A. Gray, director of the San Angelo-Tom Green County Health Unit, requested endorsement of a plan to determine who shall be classed as indigents. William J. Swann, Sterling City, moved that a committee be appointed to define indigency. The motion was seconded by Dr. Byars, but was defeated following extensive discussion. Dr. Schulze moved that the chairman appoint a committee to study what is ordinarily interpreted in the community as indigency. Carl A. Kunath, San Angelo, seconded the motion, which passed unanimously. Dr. Mitchell appointed W. D. Anderson, San Angelo, and Drs. Round and Schulze to the committee.

Dr. Gray recommended that the society approve a well child conference and antepartum and postpartum clinic, participants to be paid $7.50 per clinic of one to two hours each. William C. Hixson, San Angelo, moved, seconded by J. Frank Jones, San Angelo, that approval be granted. The motion carried.

Dr. Gray reported that the State Board of Health is willing to furnish the Tom Green Health Unit an x-ray machine if request for such a machine is endorsed by the medical society. Dr. Anderson moved, seconded by J. N. White, San Angelo, that the machine be refused. The motion carried.

The society was requested by Dr. Gray to advertise the annual orthopedic clinic in San Angelo and to invite physicians to participate in the clinic. Dr. Byars moved, seconded by R. E. Windham, San Angelo, that the request be endorsed. The motion passed.

Representatives from the Texas Association of Employers spoke, soliciting society members. No action was taken by the society, which believed the matter should be acted on by the State Medical Association.

Dr. Schulze reported on the activities of the legislative and public relations committee.

Dr. Windham requested the opinion of the society on the National Physicians Committee. Dr. Anderson, seconded by Dr. Swann, moved that the committee be endorsed. The motion carried.

Travis County Society

September 17, 1946

Cutaneous Reactions of Sulfonamides and Penicillin—J. L. Pipkin, San Antonio.
Penicillin from the Viewpoint of a Laboratory Man—S. W. Bohls, Austin.

Travis County Medical Society held its first fall meeting of the year on September 17 in the society's library at the Capital National Bank Building, Austin. C. P. Hardwicke, Austin, president, presided.

The scientific program noted above was carried out.

Third District Society

October 8-9, 1946

October 8

Remarks of the President—William A. Carroll, Claude.

SECTION ON EYE, EAR, NOSE, AND THROAT

F. B. Malone, Lubbock, Chairman.
W. D. Watkins, Lubbock, Secretary.

Chairman's Address—F. B. Malone, Lubbock.
Bronchoscopy as an Aid to Diagnosis and Treatment in Diseases of the Lungs and Tracheobronchial Tree—Ralph B. Payne, Amarillo.
Discussion—Chase S. Thompson, Lubbock.
Care of Allergy without an Allergist—J. H. Black, Dallas.
Discussion—G. S. Smith, Lubbock.
The Round Pupil in Cataract Surgery—F. H. Newton, Dallas.
Discussion—J. T. Hutchinson, Lubbock.
Vertical Muscle Imbalance—W. O. Murphy, Amarillo.
Discussion—Ben Hutchinson, Lubbock.
Avertin Anesthesia—Fred W. Standefer, Lubbock.
Discussion—G. K. Swartz, Plainview.

SECTION ON MEDICINE

R. H. McCarty, Lubbock, Chairman.
R. C. Douglas, Lubbock, Secretary.

Chairman's Address—R. H. McCarty, Lubbock.
The Unstable Diabetic—V. E. Friedewald, Big Spring.
Discussion—W. R. Klingensmith, Amarillo.
Coronary Occlusion—C. B. Batson, Lubbock.
Discussion—Dr. O'Neill, Plainview.
X-Ray Treatment of Cutaneous Lesions—H. L. Wilder, Pampa.
Shock Therapy—G. K. Swartz, Plainview.
Discussion—W. C. Dine, Amarillo.

October 9

SECTION ON OBSTETRICS AND GYNECOLOGY

Olan Key, Lubbock, Chairman.
Joseph R. Harris, Lubbock, Secretary.

Chairman's Address—Olan Key, Lubbock.
Evaluation of Endocrine Products Commonly Used in Gynecology—Stewart Taylor, Associate Professor of Gynecology and Obstetrics, University of Colorado, Denver.
Discussion—Ewell L. Hunt, Lubbock.
Rh Factor in Obstetrics—O. R. Hand, Lubbock.
Discussion—Edwin Smith, Plainview.
Pelvic Malignancies—Grider Penick, Professor of Gynecology, University of Oklahoma, Oklahoma City.
Discussion—Allen T. Stewart, Lubbock.

SECTION ON SURGERY

Sam G. Dunn, Lubbock, Chairman.
H. E. Mast, Lubbock, Secretary.

Chairman's Address—Sam G. Dunn, Lubbock.
Selection, Evaluation, and Management of the Cardiac Who Is to Undergo Major Surgery—William H. Gordon, Lubbock.
Discussion—A. E. Winsett, Amarillo.
Head Injuries—O. W. English, Lubbock.
Discussion—Don Marsalis, Amarillo.
Fractures of the Upper Extremities—H. H. Beckering, Dallas.
Discussion—J. H. Stiles, Lubbock.
Sarcoma of the Gastro-Intestinal Tract—G. V. Brindley, Temple.
Discussion—J. T. Krueger, Lubbock.

Third District Medical Society met at Hotel Lubbock in Lubbock on October 8-9 for the scientific program outlined above. A luncheon and roundtable discussion were held both days of the meeting, and a banquet was held the night of October 8. Dr. Carroll; George L. Powers, Amarillo, secretary; H. H. Latson, Amarillo, Councilor of the Third District; and A. E. Rowley, Amarillo, trustee of the State Medical Association, were introduced at the banquet, and Dr. Latson spoke briefly. Miss Joyce Watson, vocalist, and Bill Harrod, violinist, presented a musical program, and bingo was played following the banquet with prizes furnished by Lubbock-Crosby Counties Medical Society.

Fourth District Society

October 23, 1946

Invocation—Rev. H. E. Moreland, Episcopal Church, Brady.
Welcome Address—J. Earl Rudder, Mayor, Brady.
Physiology of the Adrenals Applied to Clinical Problems—Lewis Tobian, Southwestern Medical College, Dallas.
Discussion—Roy A. Hallum, Brownwood.
Antibiotics—Andres Goth, Southwestern Medical College, Dallas.
Discussion—Paul M. Wheelis, Brownwood.
Parenteral Fluid Therapy in Traumatic States—Carl Moyer Southwestern Medical College, Dallas.
Discussion—H. B. Allen, Brownwood.

Luncheon.
Irradiation in Its Application to General Medicine—Jerome H. Smith, San Angelo.
Discussion—O. N. Mayo, Brownwood.
Management of Pulmonary Edema in Cardiac Asthma—Howard Heyer, Southwestern Medical College, Dallas.
Discussion—F. T. McIntire, San Angelo.
Practical Applications of Liver Function Tests—Morton Mazer, Southwestern Medical College, Dallas.
Discussion—W. F. Benson, Brady.
Surgery of the Sympathetic Nervous Systems in Its Application to Hypertension, Duodenal Ulcer, Vascular Disease, and Pelvic Pain—Gordon F. Madding, San Angelo.
Discussion—J. S. Anderson, Brady.
Value and Limitation of Bed Rest in Treatment of Cardiac Diseases—Tinsley Harrison, Southwestern Medical College, Dallas.
Discussion—Victor E. Schulze, San Angelo.
Banquet.
Present Aims and Work of the State Medical Association of Texas—C. C. Cody, Jr., Houston, President, State Medical Association.

Fourth District Medical Society met October 23 in Brady for the program outlined above. The luncheon and banquet, which were open also to members of the District Auxiliary, were held at Hotel Brady. The remainder of the meeting was held at the First Christian Church.

H. L. Locker, Brownwood, president of the district organization, presided.

AUXILIARY NOTES

Officers of the Woman's Auxiliary to the State Medical Association of Texas: President, Mrs. George Turner, El Paso; President-Elect, Mrs. Edward C. Ferguson, Beaumont; First Vice-President, Mrs. L. B. Windham, Tyler; Second Vice-President, Mrs. V. M. Longmire, Temple; Third Vice-President, Mrs. R. E. Clark, Memphis; Fourth Vice-President, Mrs. J. E. Hogan, Big Spring; Corresponding Secretary, Mrs. Robert F. Thompson, El Paso; Recording Secretary, Mrs. M. A. Ramsdell, San Antonio; Publicity Secretary, Mrs. J. F. Campbell, Fort Worth; Treasurer, Mrs. Guy Jones, Dallas; Parliamentarian, Mrs. Joe Nichols, Atlanta.

STATE EXECUTIVE BOARD MEETING SEPTEMBER 30, 1946

The Executive Board of the Woman's Auxiliary to the State Medical Association met September 30, 1946, at the Colonial Country Club, Fort Worth, with Mrs. George Turner, El Paso, president, presiding.

The invocation was given by Mrs. S. H. Watson, Waxahachie, followed by a recitation in unison of the Auxiliary Pledge.

Mrs. M. H. Crabb, president of the Tarrant County Auxiliary, gave an address of welcome, which was responded to by Mrs. C. B. Alexander, San Antonio. Mrs. W. R. Thompson, Fort Worth, extended greetings from the past presidents.

Mrs. Edward C. Ferguson, Beaumont, president-elect, in a short message on the theme "carry on," stressed the necessity for unity and cooperation, an informed membership, and a closer relation to the State Medical Association.

Tribute was paid Mrs. R. B. Homan, El Paso, past president who died July 31, 1946, by Mrs. O. M. Marchman, Dallas. A silent prayer in her memory was also dedicated to Mrs. Henry Trigg, Fort Worth, whose husband died September 12, 1946.

Minutes of the last Board meeting were read and approved. The president reported the resignation of Mrs. George Gallaher, Harlingen, as a member of the Nominating Committee, and appointed Mrs. Leslie Moore, Dallas, to fill the vacancy. Communications from the Louisiana State Auxiliary; the President of the National Auxiliary; Dr. C. C. Cody, Jr., Houston, President of the State Medical Association; and the State Fair Commission were read, and announcement was made of the five physicians named by Dr. Cody to the Advisory Committee to the Woman's Auxiliary.

EDITOR'S NOTE.—Transactions of the Executive Board meeting of the Auxiliary have had to be exceedingly condensed for publication in the JOURNAL. Complete minutes are in the files of the Recording Secretary of the Auxiliary.

Mrs. Sam Thompson, Kerrville, moved, seconded by Mrs. J. E. Hogan, Big Spring, that the President appoint a committee from Dallas to arrange for a Texas Woman's Medical Auxiliary Day at the State Fair of Texas in October. The motion carried.

The Revision Committee, Mrs. J. Frank Clark, Georgetown, chairman, recommended that assistance be procured for the proper checking and collecting of all funds for the Student Loan Fund. Upon motion by Mrs. Mark H. Latimer, Houston, the recommendation was adopted. The committee also submitted a resolution that county auxiliary presidents be made members of the Executive Board. The resolution was adopted upon motion by Mrs. F. F. Kirby, Waco, seconded by Mrs. E. H. Marek, Yoakum.

Mrs. L. B. Windham, Tyler, took the chair while the President gave her report. Mrs. Turner reviewed activities of the 1946 annual meeting of the Woman's Auxiliary to the American Medical Association in San Francisco, which she had attended last June and July. She reported a total registration of 1,140, including more from Texas than from any other state except California. Mrs. Frank Haggard, San Antonio, served as chairman of the Nominating Committee, and Mrs. Turner was appointed to the Committee on Resolutions. Mrs. Turner noted that a complete report of the meeting appears in the August, 1946, *Bulletin.*

Mrs. Turner resumed the chair and called for reports of officers and committee chairmen.

Mrs. L. B. Windham, Tyler, first vice-president, urged either active membership or membership-at-large for each physician's wife, and suggested a supper club to meet once a month in the homes of auxiliary members at which doctors might study and discuss current problems in their practices in a spirit of good fellowship.

The importance of physical examinations was stressed by Mrs. V. M. Longmire, Temple, second vice-president.

Mrs. R. E. Clark, Memphis, third vice-president, expressed the hope that *Hygeia* distribution might be increased at least 50 per cent this year by contacting schools, physicians, dentists, libraries, civic clubs, beauty and barber shops, health nurses, and educational organizations.

Specific program suggestions were made by Mrs. J. E. Hogan, Big Spring, fourth vice-president, who emphasized the use of health films available through the Library of the State Medical Association, the State Department of Education, and the State Department of Health.

Mrs. Robert F. Thompson, El Paso, corresponding secretary, was not present but sent a report stating that stationery had been printed and made available.

Mrs. M. A. Ramsdell, San Antonio, recording secretary, reported that copies of the minutes of the May, 1946, Board meeting had been placed in the files and had been published in the TEXAS STATE JOURNAL OF MEDICINE (July, 1946, p. 219).

A request that yearbooks be sent either to her or the JOURNAL and that news items for the JOURNAL, including the "who, what, when, where, why, and how" of each story and correct names, initials, and dates, be sent regularly to arrive [illegible] of the month preceding the date of publication was made by Mrs. J. Franklin Campbell, Fort Worth, publicity secretary.

The treasurer, Mrs. Guy Jones, Dallas, reported cash on hand $10,352.77.

Mrs. A. B. Pumphrey, Fort Worth, legislative chairman, explained that the medical profession expects to urge the passage of a basic science bill and a revised medical practice act in the State Legislature this year, and that voluntary prepayment medical plans and legislation introduced by U. S. Senator Robert Taft as a substitute for the Wagner-Murray-Dingell and Pepper bills on the national level should receive the Auxiliary's attention.

An intermission in the routine business of the Board was called so that an address by Dr. Holman Taylor, Fort Worth, Secretary of the State Medical Association and member of the Advisory Committee to the Woman's Auxiliary, might be heard. Dr. Taylor covered the following points: pending legislation including the basic science bill, medical practice act bill, coroner's bill, Tuberculosis Association projects, and State Health Department program; importance of sound public relations; urgent need for solution of the nurse shortage problem; advisability of a prepaid medical service plan; possibility of a veterans medical care program conducted through the private medical profession; growing need for mental health units; centennial in 1947 of the American Medical Association; and the importance of assistance from the Auxiliary in all these matters.

When reports from committee chairmen were resumed, Mrs. H. P. Ledford, Wichita Falls, library chairman, urged the importance of contributions to the Library Fund.

Mrs. E. H. Marek, Yoakum, historian, stated that she would have to wait for annual reports to do most of her work.

A report of the George Plunkett Red Fund showed a book value of trust as of September 1, 1946, of $4,962.72.

Mrs. Marvin Duckworth, Cuero, chairman of the Resolutions Committee, presented resolutions honoring the memory of Mrs. R. B. Homan, rejoicing in the teamwork and loyalty of Auxiliary leaders, appreciating the hospitality of the Fort Worth auxiliary members, thanking Mrs. J. Franklin Campbell for the accommodations she had secured and the hotels and Colonial Country Club for their hospitality, and expressing gratitude to Mrs. A. B. Pumphrey for her entertainment and Mrs. George Turner for her generosity, courage, and ability.

Tentative plans for exhibits at the 1947 annual meeting in Dallas were sent by Mrs. J. L. Jinkins, Galveston, who was unable to be present.

Mrs. E. W. Coyle, San Antonio, Southern Medical Auxiliary chairman, wired greetings.

Mrs. W. R. Thompson, Fort Worth, memorial chairman, requested that she be notified immediately of any need for her services.

Mrs. S. M. Hill, Dallas, budget and finance chairman, had no report.

Council women and county presidents were recognized and gave brief outlines of their plans.

Mrs. Mark H. Latimer, Houston, moved, seconded by Mrs. S. F. Harrington, Dallas, that all reports be adopted as read. The motion carried.

Mrs. R. B. Anderson, Fort Worth, chairman of registration, reported sixty-one persons in attendance.

The President expressed her personal appreciation and that of the Auxiliary to Mesdames Crabb, Pumphrey, and W. F. Armstrong for their hospitality and cooperation in making possible the meeting of the Board. She requested the Revisions Committee to bring all revisions since 1942 up to date for a report at the May meeting. Her final remarks summarized most of the objectives of the Auxiliary for the year.

Adjournment was then taken.

Auxiliary members in attendance at the Executive Board meeting were guests of the President, Mrs. Turner, for luncheon at the Colonial Country Club and were entertained at a cocktail party, honoring Mrs. Turner, given by Mrs. Pumphrey in her home. A no host dinner in the smorgasbord dining room of the Blackstone Hotel completed the day's social functions.

AUXILIARY NEWS

El Paso County Auxiliary board of directors met October 9 in the home of the president, Mrs. S. J. Gaddy, El Paso, to discuss plans for the year. In addition to Mrs. Gaddy, the board is composed of Mesdames A. P. Black, president-elect; J. D. Peticolas, first vice-president; H. Earl Rogers, second vice-president; E. G. Causey, third vice-president; A. J. Eck, recording secretary; J. Paul Rigney, corresponding secretary; and R. F. Thompson, R. B. Homan, Walter H. Stevenson, and Leslie Smith.

Committee chairmen named by Mrs. Gaddy include Mesdames Leslie Smith, budget; F. P. Barrett, bylaws and constitution; J. W. Laws, courtesy; R. B. Homan, doctor's day; Russell Deter, decorations; H. W. Dietrich, exhibit; A. D. Long, historian; C. E. Jumper, Hygeia and Bulletin; J. J. Gorman, medical current events; E. G. Causey, membership; W. L. Brown, parliamentarian; F. A. Snidow, physical examination; J. D. Peticolas, public relations; Walter H. Stevenson, program; J. D. Martin, publicity; William Glasier and George Reyer, social; H. Earl Rogers, state librarian; R. F. Thompson and Newton F. Walker, legislation; C. D. Hunter and Celso Stapp, telephone; Ralph Homan, ways and means; J. Rogde and W. J. Davis, yearbook; and J. E. Morrison, George Turner, J. D. Peticolas, R. F. Thompson, E. G. Causey, A. P. Black, and Leslie Smith, Turner Memorial Home.

Galveston County Auxiliary held its first meeting of the year October 18 at Hotel Galvez. New members were honor guests at a luncheon attended by eighty-one members and thirty-nine guests—Mrs. Rose Lee Otto, Publicity.

Washington County Auxiliary held a luncheon at the St. Anthony Hotel, Brenham, on September 30, with Mrs. W. F. Hasskarl, president, presiding.

The auxiliary decided to send $10 to the student loan fund. Mrs. Hasskarl named the following committee chairmen: Mesdames Arthur Becker, social; Sam Toubin, Hygeia; W. F. Tottenham, memorial; R. H. Lenert, physical examination; C. E. Southern, program; H. L. Steinbach, membership; Roger E. Knolle, public relations and health education.

It was announced that the auxiliary would observe doctor's day, October 23, with a barbecue at the farm of Dr. and Mrs. Hasskarl.

Tarrant County Auxiliary held a luncheon October 11 at the Colonial Country Club, Fort Worth, honoring Mrs. M. H. Crabb, president. Dr. May Owen, Fort Worth, was the guest speaker, using as her subject the Rh factor in blood. She was presented by Mrs. Mal Rumph, director for the day.

Fifteenth District Auxiliary met October 8 at Fern Lake near Marshall, with the Harrison County Auxiliary as host. Nineteen members participated in a business session presided over by Mrs. Ralph Cross, Texarkana, district council woman. Mrs. F. S. Littlejohn, Marshall, was elected president; Mrs. Joe D. Nichols, Atlanta, vice-president; and Mrs. S. W. Tenney, Marshall, secretary-treasurer. Mrs. Nichols was presented as parliamentarian of the State Auxiliary and reported on a recent meeting of the State Executive Board in Fort Worth.

The auxiliary joined members of the medical society for a luncheon at which Dr. C. C. Cody, Jr., Houston, President, and Dr. Holman Taylor, Fort Worth, Secretary of the State Medical Association, spoke.

Mrs. H. P. Deady, charter member of the El Paso County Auxiliary, died October 8, 1946, in El Paso following an illness of several years. She is particularly remembered by members of the auxiliary for her teas and social courtesies to them and in recent years, when illness prevented more active participation, for contributions of flowers from her gardens. She is survived by her husband, Dr. Howard P. Deady, El Paso; and a sister, Mrs. Lula Veck, and brother, Ernest P. Miller, both of New York.

Mrs. J. A. Rawlings, El Paso, died June 23, 1946, in Philadelphia. Mrs. Rawlings was a charter member of the El Paso County Auxiliary, recording secretary in 1923, president in 1927, and chairman of many committees, including for many years the Weed Eradication Committee. She was especially interested in the eradication of weeds which cause hayfever and was instrumental in securing the cooperation of other El Paso agencies in a campaign to destroy such weeds. Mrs. Rawlings is survived by a son, Dr. Matt Rawlings, Flint, Mich.; and two daughters, Mrs. Charles Stuart Mott, Flint, Mich., and Mrs. Carl Robinson, Haddenfield, N. J.

Mrs. A. E. Sweatland, aged 72, Lufkin, Texas, resident for twenty-five years, died October 24, 1946, at her home following a stroke suffered several days previously. Mrs. Sweatland was a member of the Angelina County Medical Auxiliary and actively participated in other civic projects. She is survived by her husband, who has been Councilor of the Tenth District of the State Medical Association for many years.

BOOK NOTES

PLASTIC SURGERY JOURNAL BEGUN

The first periodical publication devoted exclusively to the field of plastic and reconstructive surgery has been started as the official journal of the American Society of Plastic and Reconstructive Surgery, which was organized in 1941, informs *The Journal of the American Medical Association* for September 21. The new bimonthly, to be called *Plastic and Reconstructive Surgery*, will carry in each issue abstracts of current international literature on plastic surgery.

[1]**Men Without Guns.** Text by DeWitt Mackenzie, War Analyst of The Associated Press. Descriptive Captions by Major Clarence Worden, Medical Department of the United States Army. Foreword by Major General Norman T. Kirk, Surgeon General of the United States Army. Illustrated with 137 Plates from the Abbott Collection of Paintings owned by the United States Government. Price, $5.00. Philadelphia and Toronto, The Blakiston Company, 1945.

"Men Without Guns" depicts, in a comparatively brief and concise manner, the activities of the men and officers of the Medical Department during World War II. Aid men, litter bearers, technicians, nurses, surgeons, dentists, veterinarians, and others are depicted as they went about their duties in the combat zones in the Southwest Pacific, Saipan, Italy, Normandy, Burma Road, and finally the road home. The wounded are also kept in the foreground. The method employed is by text and paintings by topnotch artists. The latter are excellent and on looking at them one gets the feeling of seeing the real thing. This is not so true, however, of the text, which seems to be overdrawn and overplays the matter-of-fact spirit of the average Medical Department man doing a job he knew how to do quickly and well. The book is one of which any member, or former member, of the Medical Department may well be proud. Anyone wishing to keep his reminiscences fresh should have this book in his library.

[2]**Gastro-Enterology** (in three volumes). Volume II By Henry L. Bockus, M. D., Professor of Gastro-Enterology, University of Pennsylvania Graduate School of Medicine and Colleague at University of Pennsylvania Graduate School of Medicine. The Small and Large Intestine and Peritoneum. 975 pages, fully illustrated, including many in colors. Price, $35.00 per set of three volumes. Philadelphia and London, W. B. Saunders Company, 1944.

It is now well known that Gastro-Enterology, in three volumes, by Bockus, has been completed. The first volume was reviewed in the columns of the JOURNAL more than two years ago. The second volume is devoted to the intestines and peritoneum. In compiling this second volume Bockus has the assistance of seven members of the faculty of the University of Pennsylvania Graduate School of Medicine. The subjects discussed in this second volume are exceedingly well done. This means, therefore, that Volume II compares favorably with Volume I, which was originally considered all but matchless.

The chapters dealing with regional enteritis, intestinal obstruction, and ulcerative colitis are outstanding. The active practitioner will be delighted with the brief chapter on duodenal parasites. The chapter on idiopathic steatorrhea (nontropical sprue) is one of the most concise discussions of this subject it has been my pleasure to read. Amebiasis and amebic dysentery is another delightful chapter. All of the discussions of the lesions of the colon are handled superbly. In this volume, as in Volume I, anatomy and physiology are handled briefly and pointedly, and finally, the bibliography is all that could be desired.

[3]**Diseases of the Skin.** For Practitioners and Students. By George Clinton Andrews, A.B., M.D., Associate Clinical Professor of Dermatology, College of Physicians and Surgeons, Columbia University; Chief of Clinic, Department of Dermatology, Vanderbilt Clinic; Chief of Dermatology Clinic, Roosevelt Hospital; Fellow of the American Medical Association, of the American College of Physicians, and the New York Academy of Medicine. Third edition. Cloth, 937 pages with 971 illustrations. Price $10.00. Philadelphia and London, W. B. Saunders Company, 1946.

Dr. Andrews has included in his third edition a very comprehensive review of skin diseases as seen commonly in everyday practice. He also has included many of the rarer diseases which have been reported in recent years. He has brought the treatment up to date by including the sulfonamides and penicillin in their places of usefulness.

The chapter on x-ray therapy is very thorough and fills the needs of the practitioner not wishing to delve into the physics of x-ray. Another chapter deserving attention is that on virus diseases.

The illustrations are new and are not copied from other texts, as is so often the case. Most discussions are illustrated, giving the researcher some idea of the subject matter before he reads the article.

Treatment is of a very practical nature and includes, in many instances, prescriptions which are useful in the particular disease. The author mentions modalities which would be useful in each discussion, such as x-ray or ultraviolet light.

I recommend this book as one of the most practical and useful books a medical man could have as a reference in time of need.

[4]**Preoperative and Postoperative Treatment.** Edited by Lt. Col. Robert L. Mason, M.C., A.U.S., Cushing General Hospital, Framingham, Mass., and Harold A. Zintel, M.D., Harrison Department of Surgical Research, University of Pennsylvania School of Medicine; Assistant Surgeon, Hospital of the University of Pennsylvania. Second edition. Illustrated. Cloth, 534 pages. Price, $7.00. Philadelphia and London, W. B. Saunders Company, 1946.

[1]Reviewed by Sim Hulsey, M. D., Fort Worth.
[2]Reviewed by George M. Underwood, M. D., Dallas.
[3]Reviewed by J. Franklin Campbell, M. D., Fort Worth.
[4]Reviewed by Hudson Dunlap, M. D., Dallas.

Twenty contributors have brought their ideas on preoperative and postoperative care to us in this very excellent book. This is not a routine review of the subject, but is rather a careful, interesting, and stimulating discussion of the physiology, bacteriology, biochemistry, and pharmacology involved.

The book is divided into two parts, namely, general and regional. In the former there are excellent chapters on such subjects as shock, water balance, ileus, thrombosis, and burns. In the latter part, the preoperative and postoperative care of patients with hyperthyroidism, biliary tract disease, intestinal obstruction, and many other of the common surgical disorders is thoroughly covered.

This is a book which should be available to all who are interested in surgery.

DEATHS*

Dr. Henry Bowlin Trigg, Fort Worth, Texas, died September 12, 1946, of cirrhosis of the liver.

The son of Daniel Curd and Sally (Bowlin) Trigg, Dr. Trigg was born May 27, 1880, at Grapevine but moved with his family to Fort Worth in 1890. He attended the Fort Worth public schools and was graduated in 1904 from the old Fort Worth School of Medicine. His internship was served at Bellevue Hospital, New York. He later did postgraduate work at the Medical School of Reclamation Surgery in Berlin, Guys Hospital in London and the Sacred Heart Hospital in Paris. In 1912 Dr. Trigg and his brother, Dr. Ross Trigg, became partners in Fort Worth, specializing in industrial surgery. During World War I, Dr. Trigg served with the industrial service at Hicks Field, and during World War II, he served at Camps Swift and Hood. He had retired from active practice last April.

DR. HENRY B. TRIGG

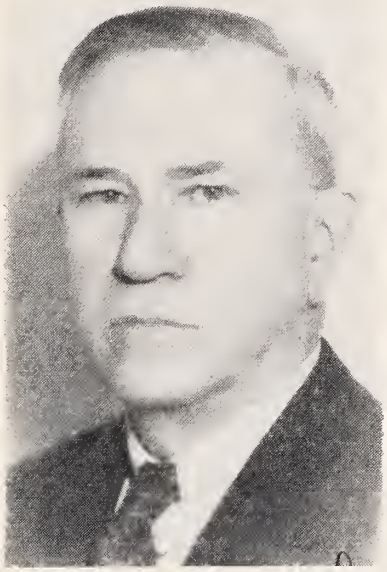
Throughout his professional life Dr. Trigg was a member of the Tarrant County Medical Society, State Medical Association, and American Medical Associaciation. He was a member of the Episcopal Church, Masonic order, and Fort Worth Club.

On March 22, 1911, Dr. Trigg married Miss Nellie Day, who survives. Also surviving are one son, James Henry Trigg, Cerrillos, N. M.; three daughters, Mrs. Mary Elizabeth Allen, Burbank, Calif.; Mrs. Margaret Day Gloss, Redwood City, Calif.; and Mrs. Sally Haentjens, Hazleton, Pa., two brothers, Dr. Ross Trigg, Fort Worth, and Dr. Dan Trigg, Tucumcari, N. M.; and four sisters, Mrs. Margaret Boyle, Mrs. George C. Robinson, and Miss Mary Trigg, all of Fort Worth, and Mrs. Frank C. Riker, Council Bluffs, Iowa.

As the family requested that no flowers be sent in tribute to Dr. Trigg, his friends instead have honored him by donating thousands of dollars in his name to worthy projects, among them loan funds for needy medical students, cancer control funds, Shrine crippled children's hospitals, free milk and ice funds, Christmas cheer funds for Fort Worth children, and the State Garden Club.

Dr. John Howell McLean, Fort Worth, Texas, died in a local hospital September 20, 1946, of acute hemorrhagic nephritis.

Dr. McLean was born in Mount Pleasant, Texas, June 11, 1877, the son of William Pinkney and Margaret (Batte) McLean. His father, a major in the Confederate Army and an outstanding lawyer, was a member of the Texas Legislature, the first Railroad Commission of Texas, and the United States Congress. Dr. McLean received a bachelor of arts degree from Southwestern Presbyterian University, Clarksville, Tenn., in 1896, being graduated with honors. He was graduated from the medical department of Fort Worth University in 1901, winning prizes for proficiency in pediatrics, anatomy, and general excellence, and being graduated with honors and as valedictorian of his class. He did additional medical study at Cornell University, New York, completing a doctor of medicine degree with second highest honors in 1904. He served a two year residency at Bellevue Hospital, New York, before returning to Fort Worth to open the practice in which he was active until shortly before his death. He took postgraduate work in various centers during his career.



DR. JOHN H. McLEAN

Throughout his professional career Dr. McLean was a member of Tarrant County Medical Society, the State Medical Association, and American Medical Association. He was a charter member of the Tarrant society and was its president in 1919. He was chairman of the Section on Obstetrics and Gynecology of the State Medical Association in 1926 and again in 1940. He was president of the old North Texas Medical Society in 1921, and was a member of the Northwest Texas Medical Society after Tarrant County became part of the Northwest District. He had been a fellow of the American College of Surgeons since 1915, was a member of the board of trustees of the American Hospital in France, and was staff member of most of the Fort Worth hospitals. He was professor of gynecology in the old Fort Worth University medical department and was dean of the Nurses Training School of All Saints Hospital for many years. He was twice a member of the Texas State Board of Medical Examiners for a total of six years. During World

*An obituary ordinarily will not be published more than four months after date of death. Coöperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

War II he served on the board of appeals for Selective Service and received a medal for his work.

Of Dr. McLean's many civic contributions, perhaps the most outstanding service was to the Panther Boys Club of Fort Worth, of which he was a director continuously from shortly after its organization in 1926 until his death. He also served as its president from 1932 until a short while before his death when he resigned because of ill health. His work with that organization in particular is a monument to his memory. It is known that thousands of Panther boys knew Dr. McLean personally and took their problems to him. His many charities were known only to his closest associates.

Dr. McLean was especially interested in politics, both of the state and the nation. He was an active member of the State Democratic Executive Committee for a number of years. He was a member of the Episcopal Church, a Mason, a member of the Shrine, a Knight Templar, and a member of the Fort Worth Club. He was a former member of the Elks, Lions Club, and Kiwanis Club.

Surviving Dr. McLean are his wife, the former Miss Anita Hunter, of Fort Worth; a daughter, Mrs. T. A. Robinson, Houston; a son, William Hunter McLean, Fort Worth; two sisters, Miss Margaret McLean, Fort Worth, and Mrs. Grady H. Culp, Gainesville; and two grandchildren.

Dr. Gordon Phillips, Haskell, Texas, died August 22, 1946, in an Abilene hospital of epidural abscess and double lobar pneumonia.

Dr. Phillips, the son of Mr. and Mrs. T. B. Phillips, was born July 16, 1907, at Crawford. He received his academic education at Baylor University, Waco, and was graduated from the University of Texas School of Medicine, Galveston, in 1933. He served an internship at the General Hospital, Wichita Falls, and was assistant city health officer in Wichita Falls in 1934. In 1935 he began practice at Haskell, which remained his home until his death. He served four years as a captain in the Army Medical Corps, being released in May, 1946.

DR. GORDON PHILLIPS

Since 1935 Dr. Phillips had been a member of the State Medical Association and American Medical Association, first through Wichita County Medical Society and then through Baylor-Knox-Haskell Counties Medical Society. He was a member of the Baptist Church and a Mason.

Surviving Dr. Phillips are his wife, the former Miss Roberta Hall, whom he married in November, 1937, at Wichita Falls; his parents, Mr. and Mrs. T. B. Phillips, Crawford; a sister, Mrs. W. W. Callan, Waco; and two brothers, Harold Phillips, Brownsville, and James Phillips, Crawford. He was preceded in death by a brother, Toby B. Phillips, who was killed in military service.

Dr. Joseph Wilmer Cox died at his home in Groesbeck, Texas, on September 17, 1946, following an extended illness.

Born November 11, 1867, in West Feliciana Parish, La., Dr. Cox was the son of Dr. William T. and Sarah (Doherty) Cox. Upon his graduation from the medical department of Tulane University in 1893, he came to Limestone County, Texas, to open his practice and remained there until ill health forced his retirement recently. In 1921 he founded the Cox Hospital in Groesbeck. During his career he had done postgraduate work at New York, Baltimore, Chicago, Philadelphia, and New Orleans.

DR. JOSEPH W. COX

Almost continuously throughout his professional career Dr. Cox was a member of the State Medical Association and American Medical Association through Limestone County Medical Society. He was president of Limestone County Society in 1936-1937. He was a fellow of the American College of Surgeons. He was a member of the Methodist Church and a Mason.

In 1895 Dr. Cox married Miss Ada Coleman Tyus, who preceded him in death in 1921. One son, Dr. Henry Tyus Cox, died in 1935, and another, Dr. William Lester Cox, in 1931. Survivors include a son, Dr. Stanley Cox; a daughter, Frances Elizabeth Cox; a grandson, Joseph Henry Cox; and a sister, Mrs. J. R. Stroud, all of Groesbeck.

Dr. Henry Matthias Haynes, Gatesville, Texas, died of coronary thrombosis August 22, 1946.

The son of Mr. and Mrs. Sam Haynes, Dr. Haynes was born September 29, 1876, in San Saba County. He attended the public schools at Salado and DeLeon, the Memphis, Tenn., Hospital Medical College, and the old Dallas Medical College, from which he was graduated in 1904. He began the practice of medicine at Pottsville, moved to Pearl, and then to Gatesville, where he was in practice for thirty-two years. From January until April, 1946, he was in practice with his son at Andrews, but he had retired and returned to Gatesville to supervise his ranch at the time of his death.

Throughout his professional career, with the exception of only a few years, Dr. Haynes was a member of the State Medical Association and American Medical Association through Coryell County Medical Society. In 1936 he was president of the Coryell society. He served for many years as city health officer of Gatesville.

Dr. Haynes on August 5, 1906, married Miss Georgie Edmondson, who preceded him in death in February, 1945. Survivors include one son, Dr. Henry M. Haynes, Jr., Odessa; three brothers, Allen Haynes, Killeen; Jim Haynes, Desdemona; and Bob Haynes, Stephenville; and one sister, Mrs. Ada Glover, DeLeon.

Dr. Harry Breckenridge Jacobson, Dallas, Texas, died August 31, 1946, of coronary disease.

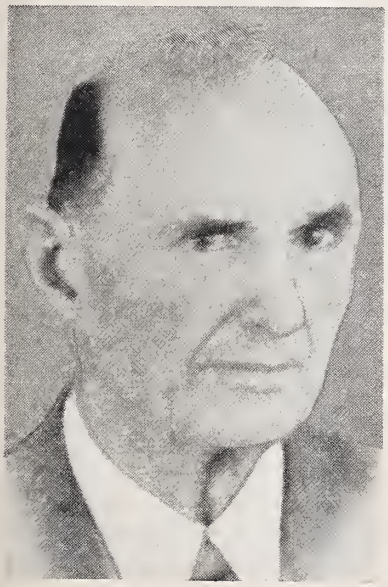
Dr. Jacobson was the son of Jacob and Josephine (Benda) Jacobson and was born October 10, 1890, at Morrillton, Ark. He attended the University of Arkansas and Washington University, St. Louis, before obtaining his medical education at Tulane University School of Medicine. He was graduated from the latter institution in 1918 and served his internship at Bellevue Hospital and Lying-in Hospital, New York, and Harper Hospital, Detroit, before locating in Dallas in 1921. He continued the practice of medicine in Dallas until his death.

From 1922 until his death Dr. Jacobson was a member of the Dallas County Medical Society, State Medical Association, and American Medical Association. He was a member of Temple Emanu-El, B'nai B'rith, Phi Delta Epsilon fraternity, and the Columbian Club. He served as medical examiner for Selective Service during the past four years.

Survivors include two sisters, Mrs. Elsie Israel, Dallas, and Mrs. Seymour L. Florsheim, Shreveport, La.; and two brothers, Charles Jacobson and Adolph Jacobson, both of Little Rock, Ark.

Dr. Oscar Henry Shepard, O'Donnell, Texas, died August 25, 1946, in a Lubbock hospital from a blood clot in the heart.

The son of Henry and Sarah Shepard, Dr. Shepard was born in 1866 at Mount Pleasant. He attended the public schools of Mount Pleasant and received his medical education from the old Fort Worth School of Medicine, from which he was graduated in 1905. He practiced for twenty years at Morgan Mill, and then moved to O'Donnell, where he was active another twenty years.



DR. O. H. SHEPARD

Dr. Shepard maintained membership throughout his professional life in the State Medical Association and American Medical Association, first through Erath County Medical Society and then through Dawson-Lynn-Terrell-Gaines-Yoakum Counties Medical Society. He had been a member of the Methodist Church for sixty-five years. In 1941 he volunteered to examine men called into military service.

In 1891 Dr. Shepard married Miss Laura Perry at Fort Worth. In 1940 he married Miss Bonnie Rochell, of O'Donnell, who survives. Also surviving are two daughters, Mrs. Floy Ramey and Mrs. Elsie Moose, both of San Bernardino, Calif,; a sister, Mrs. Lula Hammock, Munday; and a brother, E. E. Shepard, Atoka, Okla.

Dr. Samuel David Terry, Goodlett, Texas, died suddenly May 8, 1946, of heart disease.

The son of Mr. and Mrs. J. J. Terry, Dr. Terry was born June 19, 1868, in Smith County, Miss. His father died when the boy was 3 years old, and he grew up working his way by farming. After attending the elementary and high schools of Mississippi, he was graduated from Milsap College, Jackson, Miss., and moved to Texas to teach school. After teaching a number of places in Texas and Oklahoma, he attended Gate City Medical College in Texarkana and was graduated in 1907. He practiced for a short time in Hedley, but moved within a few months to Goodlett, where he was actively engaged in his profession until his death. During the thirty-nine years of his practice, Dr. Terry did postgraduate work on several occasions at Tulane University, New Orleans. He volunteered for service in World War I but did not enter active service because armistice was declared.

Dr. Terry was a member of the State Medical Association and American Medical Association through the Hardeman-Cottle and then the Hardeman-Cottle-Foard-Motley Counties Medical Society almost continuously for thirty years. He was a member of the Baptist Church and a Mason.

Dr. Terry married Miss Annie Maude Jones at Paradise, Texas, in 1902. Mrs. Terry preceded him in death July 13, 1934. Survivors include three sons, H. Chilton Terry, Quanah; Hylos N. Terry, Goodlett; and Wayne R. Terry, Kress; three brothers, J. J. Terry, Laurel, Miss.; Lewis Terry and Eugene Terry, Mendenhall, Miss.; and two sisters, Mrs. Clara Gates, Mendenhall, Miss., and Emma Terry, Jackson, Miss.

Dr. Martin A. Bernfield died at his home in San Antonio, Texas, on August 22, 1946, of coronary thrombosis, myocardial infarction, and a saddle embolus of the abdominal aorta.

Dr. Bernfield was born July 19, 1892 in Jaffa, Palestine. His preliminary education was received at the Kiev Polytechnic Institute in Russia, and his professional studies were begun at the Kiev University Medical School, where he also organized a publishing house to produce standard medical texts in the Russian language. Dr. Bernfield had a wide knowledge of languages including Russian, German, Polish, Italian, English, and most of the Slavic dialects.

DR. MARTIN A. BERNFIELD

The outbreak of World War I interrupted Dr. Bernfield's studies and during the war years he served as an intelligence officer in the Russian Army. During the Russian Revolution which followed, all of Dr. Bernfield's family except himself were killed and the family estate dissipated. After escaping from Russia he joined the British Army and served in the Upper Sudan campaign in 1919.

Dr. Bernfield came to the United States and entered the University of Michigan at Ann Arbor. He there received a bachelor of science in medicine degree in 1928 and a doctor of medicine degree in 1929. His internship was served at Receiving Hospital, De-

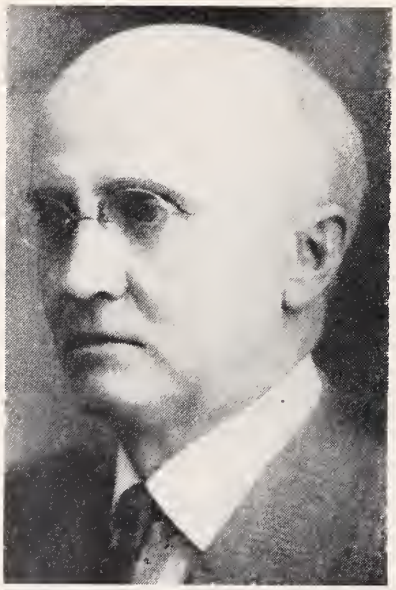
troit. He was resident physician at the Rhode Island State Hospital, Howard, R. I., and later at the Traverse City State Hospital, Traverse City, Mich. He practiced in Texas most of the time from 1931 to 1946, first in Harlingen and later in San Antonio. At the outbreak of World War II he was commissioned Passed Assistant Surgeon, U. S. Public Health Service with the rank of captain. At the time of his death he was associated with the San Antonio regional office of the Veterans Administration as medical officer full grade, neuropsychiatric examiner.

Since 1941 Dr. Bernfield has been a member of the State Medical Association and American Medical Association through Bexar County Medical Society. He was also active in the American Legion.

Survivors include Dr. Bernfield's wife, Helen Cannon-Bernfield, M. D., whom he married while at the University of Michigan, and his son, Arnold Bernfield, now a student at the University of Michigan.

Dr. Edwin Pinckney Becton, Greenville, Texas, died August 7, 1946, of chronic myocarditis and myocardial degeneration, with rectal fistulae, essential hypertension, and arthritis as contributing factors.

Born January 18, 1878, at Terrell, Dr. Becton moved within a few months to Sulphur Springs with his parents, Dr. E. P. and Olivia (Lewis) Becton. He attended Central College in Sulphur Springs, Austin College in Sherman, McKinney Collegiate Institute in McKinney, Southwestern University in Georgetown, and Bethel College in Russellville, Ky., before entering the medical department of the University of Tennessee. Upon his graduation in 1902, Dr. Becton returned to Sulphur Springs to practice for one year, and then moved to Greenville. For ten years he was in partnership with his brother, Dr. Joe Becton, Sr. The partnership was dissolved, and Dr. Becton established his own surgical hospital, which he operated until ill health forced his retirement several months prior to his death. Dr. Becton was a regular attendant upon postgraduate courses, studying in Kansas City, St. Louis, Chicago, Rochester, Minn., and Canada.



DR. EDWIN P. BECTON

From the time of his graduation in medicine, Dr. Becton was a member of the State Medical Association and American Medical Association through Hunt County Medical Society. He was a fellow of the American Medical Association, and a member of North Texas Medical Society, Inter-State Post Graduate Medical Assembly of South Texas, Dallas Surgical Clinic, and Inter-State Medical Association of North America. He was past president of Hunt County Medical Society and a member of the Texas State Board of Medical Examiners from 1907 to 1911, serving as chairman of its committee on reciprocity and of its committee to draft new certificates for 1907. For many years he had been vice-president and director and member of the examining committee of the Greenville National Exchange Bank, and for a number of years he was a stockholder and director of the Royse City Bank. He was a member of the Presbyterian Church and a Mason.

Survivors include one nephew, Dr. Joe Becton, Greenville, and three nieces, Mrs. Anna Becton Boykin and Mrs. Mamie Becton Collier, both of Greenville, and Mrs. Edgar Browning, Dallas.

Dr. Charles Bullard Williams, Mineral Wells, Texas, died September 4, 1946, of cerebral hemorrhage.

Son of Mr. and Mrs. Ben D. Williams, Dr. Williams was born at Bonham on August 19, 1874. He attended the public schools of Mineral Wells, where he moved with his father after his mother's death, and was graduated in 1899 from the Medical Department of the University of Texas. After serving an internship at John Sealy Hospital, Galveston, he returned to Mineral Wells to open the practice which he continued until shortly before his death. Dr. Williams did postgraduate work in Chicago and New York and specialized in eye, ear, nose, and throat. Upon the graduation from medical school of his son, Dr. C. R. Williams, the two established the Williams Clinic in Mineral Wells and practiced together except during the recent war when Dr. C. B. Williams carried on alone while his son was serving with the military forces in India.

DR. CHARLES B. WILLIAMS

Throughout his professional career Dr. Williams was a member of the State Medical Association and American Medical Association through the Palo Pinto County Medical Society and, upon its organization, the Palo Pinto-Parker Counties Medical Society. He was Councilor of the Thirteenth District from 1915 to 1918 and president of the Palo Pinto-Parker Society in 1940. At the time of his death he was president of the Texas Ophthalmological and Otolaryngological Society, a fellow of the American College of Surgeons, diplomate of the American Board of Otolaryngology, member of the Fort Worth Eye, Ear, Nose, and Throat Society, member and elder in the Presbyterian Church, a Mason, and a member of the Mineral Wells Chamber of Commerce. He had received citations from President Woodrow Wilson, Franklin D. Roosevelt, and Harry Truman for his voluntary work in two wars.

Dr. Williams is survived by his wife, the former Mrs. Emmie Cameron Schober; one son, Dr. C. R. Williams, Mineral Wells; a stepdaughter, Mrs. George Green, Sweetwater; two stepsons, Louis Schober, Washington, and George Schober, New York; and two foster sons, Bob Childs and Charles Childs, both of Mineral Wells.

Texas State Journal of Medicine

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Vol. XLII **December, 1946** **No. 8**

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION AND PUBLIC HEALTH IN TEXAS

The International Post Graduate Medical Assembly of Southwest Texas, sponsored principally by physicians of the Fifth and Sixth Councilor Districts of the Association but enjoyed and attended by doctors throughout Texas, resumes its annual clinical programs at San Antonio, January 28, 29, and 30, 1947, after a lapse of five years caused by World War II. This will be the eleventh scientific session of the Assembly.

Registration will begin promptly at 8:00 a. m. each day in the Municipal Auditorium. There will be General Assemblies each of the three days in the main part of the Auditorium, making it possible for all in attendance to hear all of the guest speakers. Clinical luncheons will also be held on each of the three days, sponsored by the various sections, and featuring the guest speakers. The afternoons will be given to clinical-pathological conferences, participated in both by guest speakers and by local physicians.

The following list of guest speakers assures an outstanding scientific program:

Dr. M. A. Blankenhorn, Director of Department of Internal Medicine, Cincinnati General Hospital, University of Cincinnati College of Medicine, Cincinnati.

Dr. Willard R. Cooke, Professor of Obstetrics and Gynecology, University of Texas Medical Branch, Galveston.

Dr. Austin I. Dodson, Attending Urologist, St. Elizabeth's Hospital, Richmond, Va.

Dr. William E. Gallie, Professor of Surgery, Banting Institute, Toronto, Canada.

Dr. Howard K. Gray, Chief of Surgical Section, Mayo Clinic, Rochester, Minn.

Dr. Francis E. LeJeune, New Orleans, La.

Dr. John McLean, Cornell University Medical School, New York.

Dr. Demetrio Sodi Pallares, National Institute of Cardiology, Mexico, D. F.

Dr. Henry G. Poncher, Professor and Head of Department of Pediatrics, University of Illinois College of Medicine, Chicago.

Dr. Edward H. Rynearson, Clinical Section, Mayo Clinic, Rochester, Minn.

Dr. Owen H. Wangensteen, Chief of Department of Surgery, University of Minnesota Medical School, Minneapolis.

Dr. Shields Warren, Pathologist, New England Deaconess Hospital, Boston.

Dr. Fred Wise, New York.

There will be technical and scientific exhibits, including motion pictures.

The subjects selected for the addresses of the guests are topical and cover practically every phase of medicine. This Assembly program presents an excellent opportunity for the medical profession of the Southwest to enjoy an intensive period of postgraduate instruction at home, which is gladly shared with other physicians throughout Texas or elsewhere who are members of their county and state medical associations. A registration fee of $15 covers all features of the Assembly program, including the clinical luncheons each day and a banquet at the Olmos Club the evening of the first day, January 28. The hospitality and ability of physicians of San Antonio to produce attractive scientific meetings is assurance that the 1947 Assembly will be well worth attending both from a scientific and good fellowship standpoint.

Texas Laws Pertaining to Inquests on the Cause of Death are outmoded and should be brought up to date and made effective. Physicians and others who have had to do with such matters in recent years have been keenly aware of the deficiencies in these laws, and, during the last session of the Legislature, it will be remembered that an attempt was made to pass a corrective bill. It will be further remembered that constitu-

tional difficulties were encountered and the bill had to be rewritten. A substitute measure prepared by the Attorney General's department was introduced, and it is believed would have become a law had there been time enough. Since the adjournment of the last Legislature, the need of such legislation has been emphasized by a number of incidents, some of them important, some of them not, but all of them pointing to the need of doing something about it, and something about it is due to be done.

A bill has been prepared and will be introduced in the forthcoming Legislature, which, it is thought, will correct a bad situation. The original versions of two years ago have been used in developing the new measure. The pathologists of the state warmly approved the idea, and also the bill as published elsewhere in this number (p. 501). The Executive Council of the State Medical Association likewise has endorsed the proposed legislation.

The revamped bill amends the present Articles of our Code of Criminal Procedures and other laws concerning inquests. Under the proposed bill any justice of the peace will be required to hold inquests in the following cases: (1) when a person dies in prison or in jail; (2) when any person is killed, or from any cause dies an unnatural death, except under sentence of the law, or dies in the absence of one or more good witnesses; (3) when the body of a human being is found, and the circumstances of his death are unknown; (4) when the circumstances of the death of any person are such as to lead to suspicion that he came to his death by unlawful means; (5) when any person commits suicide, or the circumstances of his death are such as to lead to suspicion that he committed suicide; (6) when a person dies without having been attended by a duly licensed and practicing physician, and the local health officer or registrar of vital statistics does not know the cause of death; and (7) when a person dies who has been attended by a duly licensed practicing physician or physicians, and such physician or physicians are not certain as to the cause of death.

The inquests thus authorized shall be held by the justice of the peace in the precinct in which the death occurred, or, in the event such justice of the peace is not available, or fails or refuses to act, the inquest shall be conducted by the nearest available justice of the peace.

The justice of the peace may cause a body upon which an inquest should have been held, to be disinterred for the purpose of holding such inquest, and autopsy shall be required prior to the cremation of any such body.

When attending physicians are not able to certify to the cause of death, they shall report the matter to the justice of the peace in the precinct in which the death occurred, and request an inquest. The same rule applies to the superintendent or general manager of a hospital or institution in which such deceased shall have died.

When the justice of the peace holds an inquest, he shall in all cases call in the county health officer where there is one, or a duly licensed and practicing physician where there is no county health officer, for the purpose of determining whether an autopsy is indicated or necessary. This is an important addition to the present law pertaining to the matter, the justice of the peace now having full authority to diagnose the case and make decision as to what shall be done about it. The new provision would throw medical light upon the subject.

The justice of the peace shall have authority to procure an autopsy in any case where one is indicated, and when there is indication of poisoning, the justice of the peace shall have authority to employ some medical expert, chemist, toxicologist, or licensed physician practicing pathology, qualified to make an analysis of the stomach and its contents, together with such other portions of the body as may be necessary to be analyzed and tested before determination is made.

In a case where death has occurred without medical attention, it is made the duty of the undertaker to notify the local registrar of the death, and the local registrar intervenes to bring about an inquest and whatever should transpire under that procedure. It will become the duty of the justice of the peace to furnish the registrar with the data required properly to classify the death. An important phase of the measure is that it provides that where a duly licensed physician performs an autopsy as ordered by the justice of the peace, in good faith and believing the order to be valid, the physician is not liable for any damage in the event it should be determined that the order for the autopsy is invalid. This provision is not retroactive.

It is not believed that there will be any organized opposition to the bill. On the contrary, it is felt that there are many, including physicians, who believe that something of the sort is necessary.

Medical Service in World War II will be subjected to a careful, painstaking study and critical analysis by a special committee of the American Medical Association appointed by the Board of Trustees in compliance with the action of the House of Delegates at the 1945 meeting. The committee, designated as the

National Emergency Medical Service Committee, first prepared a pilot questionnaire which was sent to 1,000 former medical officers selected at random throughout the nation. Forty-seven per cent of the pilot questionnaires were executed and returned, indicating the very great interest of these physicians in improving medical service for the Armed Forces and the conditions under which it will be rendered in national emergencies of the future. Technical defects noted in the returns of the pilot questionnaire were corrected, and during November, 1946, a revised questionnaire is being addressed to the 45,000 medical officers who served with military forces of the nation during World War II.

During the war and since its conclusion many critical letters were received in the headquarters office of the American Medical Association from physicians who served in the Armed Forces. Some of these letters were extremely bitter, expressing resentment because of conditions under which medical officers were required to serve, and complaining of such factors as methods of recruiting; rank received when commissioned; lack of and what was considered unfair promotion; wasted time as the result of too many medical officers for the number of forces served; assignment to nonprofessional duties that could easily have been cared for by others than physicians; seeming disregard for special training of medical officers, such as the assignment of pediatricians to sanitary inspections or eye, ear, nose, and throat specialists to general surgery; and many others too numerous to refer to here. Some of the complainants seemed to feel that the American Medical Association was to blame for it all, which of course is not true. Many efforts have been made in the past by the American Medical Association to correct what appear to be inequities and defects of the medical department of the Armed Forces but with little success.

The present study will be by far the most comprehensive, earnest effort yet made to determine what can and should be done to make most effective the services rendered by civilian physicians called into service in times of national crisis. The success of this effort will depend largely upon the thoughtful execution of the questionnaires sent to the physicians who served in World War II and have since returned to civil life. Texas physicians receiving the questionnaires are urged to take the time necessary to give the best answers of which they are capable in order that the special training, knowledge, and skill of the medical profession in future national emergencies may be utilized most effectively by the Armed Forces, while at the same time the civilian population, which must produce the tools of war, will be adequately cared for.

Distribution of Surplus Military Dried Blood Plasma, begun in Texas in February, 1946, by the State Health Department after receipt of an initial shipment from the American Red Cross, is still in progress. It will be recalled that the sudden cessation of hostilities in World War II, which came sooner than expected, found the Army and Navy with greater quantities of blood plasma on hand than could be used during its anticipated useful life, namely, five years from the date of its processing. The surplus amounted approximately to one and a quarter million one-unit packages. Public Law 457 of the 78th Congress, approved October 3, 1944, provided for the transfer of the dried plasma declared surplus to the American Red Cross, with the distinct provision that it should be used "solely for charitable purposes." The Red Cross felt that this surplus plasma should be returned to the American people who had donated it, for use in veterans' hospitals and in civilian medical practice. A plan for its distribution through state health departments was formulated and was submitted to and approved by the House of Delegates of the American Medical Association in 1945.

Briefly, the plan provided that the plasma be apportioned to the several states through their respective health departments on a population basis, weighted by the number of physicians and the number of general, pediatric, and maternal hospital beds, for "distribution without charge" to physicians and acceptable hospitals "for use in the treatment of any patient without charge for the product."

The initial shipment to Texas was 12,852 packages, received on February 1, 1946. This apportionment was calculated on the basis of one package for each licensed physician in the state (6,952), and one package for every four general, pediatric, and maternity hospital beds (4,728) plus a 10 per cent increase. This shipment had been entirely distributed by the State Health Department by August, 1946. To date, according to Dr. George W. Cox, State Health Officer, 18,852 units of the surplus plasma have been received and 16,338 units have been distributed to 212 hospitals and sixty-five individual physicians. Many hospitals have received second shipments.

Dr. Cox urges that hospitals and physicians who have not received their quotas* of

*EDITOR'S NOTE.—A complete discussion of the American Red Cross plan for distribution and use of the surplus plasma, presented to and concurred in by the Association of State and Territorial Health Officers, the American Medical Association, and the American Hospital Association, was published in *The Journal of the American Medical Association*, December 29, 1945, page 1275.

the plasma make requests as early as possible. Attention is called to the stipulation that no charges are to be made to patients receiving the plasma, that it is intended for return "to the people who gave it, for all who request it, as long as it lasts, and there are to be no economic restrictions on its use." The restriction as to charges refers to the product and not to its administration.

The Texas Physicians Committee of the National Physicians Committee for the Extension of Medical Service was established at a meeting in Dallas, September 8, of ninety physicians from all parts of the state, called by Dr. C. C. Cody, of Houston, who served as temporary chairman. A report of a nominating committee was adopted unanimously, naming the following officers and executive board for the permanent organization: chairman, Dr. F. J. L. Blasingame, Wharton; vice-chairman, Dr. E. A. Rowley, Amarillo; secretary-treasurer, Dr. X. R. Hyde, Fort Worth; executive board, Drs. Ralph H. Homan, El Paso; M. H. Bennett, Big Spring; R. R. Swindell, Amarillo; James S. Anderson, Brady; W. B. Russ, San Antonio; W. E. Whigham, McAllen; George Allen, Burnet; Harvey Renger, Hallettsville; J. G. Heard, Houston; L. C. Powell, Beaumont; Thomas M. Jarmon, Tyler; James C. Terrell, Stephenville; W. R. Snow, Abilene; George Schenewerk, Dallas; and L. C. Heare, Port Arthur.

During the morning session, following the organization, a comprehensive discussion of the purposes, objectives, and accomplishments of the National Physicians Committee was presented by Edward F. Stegen, Associate Administrator. During the afternoon session, Arthur L. Conrad, also of the National Physicians Committee, described the manner in which public hearings were conducted on the Wagner-Murray bill by the Senate Committee on Education and Labor in Washington.

Following the general sessions, the executive board met and voted that immediate steps should be taken to secure the financial and wholehearted support of the medical profession of Texas for the program of the National Physicians Committee, the purpose of which is to preserve American Medicine and to defeat the aims of those who would regiment the public and the medical profession of the United States.

Since the meeting, physicians of Texas have been circularized by Chairman Blasingame, asking financial support for the Committee, which has stimulated interest and inquiries regarding the matter.

First, it should be said that neither the Texas Physicians Committee nor the National Physicians Committee has any connection, official, financial, or otherwise, with the State Medical Association of Texas. The Texas Physicians Committee is a part of the National Physicians Committee and money given to the former will help finance the program of the national organization combating the movement to socialize medicine in the United States.

Second, it should be recorded again that the work and program of the National Physicians Committee has been repeatedly approved and commended officially by the American Medical Association and the State Medical Association of Texas.

Third, in answer to the fairly frequent question, what is the need for a national organization such as the National Physicians Committee since state medical associations have instituted vigorous programs of public relations, the latter would fall far short of their objectives without the implementation and correlation given to them by a nationwide program. The American Medical Association itself cannot do the work that has been done so effectively by the National Physicians Committee without being subjected to the likelihood of having to pay income taxes. If that should happen, the comprehensive research and unparalleled scientific program of the American Medical Association would be sadly curtailed and, in fact, practically done away with. That was the reason for the organization of the National Physicians Committee in the first place.

Physicians of the United States owe to this Committee a debt similar to that which the people of this country owe England for what she accomplished during World War II in holding the Nazi hordes at bay until America could prepare herself for war. The National Physicians Committee must be given credit for the magnificent job it did in combating compulsory sickness insurance in the United States until state medical associations could initiate public relations programs of their own. The story of what the N. P. C. has done and is doing is too long to tell here. Suffice it to say that the physicians of Texas may rest assured that the organization and program is sound, orthodox from the standpoint of medicine, well managed, and is doing an outstanding job. It is deserving of strong financial and moral support. Without it we in Texas would find our own efforts far more difficult.

And no Texas physician familiar with leaders in Texas medicine will for a moment question the motives or integrity of those who have been selected to head the newly formed Texas Physicians Committee of the

National Physicians Committee for the Extension of Medical Service. They merit our thanks and should and will receive our support.

The Christmas Seal Sale is called to the attention of our readers because of both general and special interests. The entire population is interested in the sale because the money realized therefrom is used in the crusade against tuberculosis. Doctors have a special interest in the matter because of their contacts with patients suffering from the disease. As a matter of fact, there is no responsibility involved other than that of the public as a whole, but there is and must be a special, impelling interest on the part of the doctor. It is expected that the medical profession will do its part and more in pushing the sale of Christmas Seals, and buy its share of them.

The fight against tuberculosis has been a long drawn out affair. Indeed, the fight against all diseases has been rather long drawn out, but the campaign against tuberculosis is the first organized campaign of the sort. It is succeeding. It is more desperately in need of help because of that fact. Now is not the time to lose interest in the movement. Indeed, the State Medical Association has renewed its interest in the fight on tuberculosis. It has recently set up a committee on a continuing basis, with instructions to give no quarter.

The National Tuberculosis Association is one of the truly orthodox lay health and welfare organizations in the country, and the Texas Tuberculosis Association is in constant and consistent coöperation with the State Medical Association of Texas. These organizations own the Christmas Seals.

Pay Dues Early. There is a reason. As announced in these columns last month, the fiscal year of the State Medical Association has been changed to accord with the calendar year, which is the membership year. As was explained last month, there will be no actual change in membership status, the membership year having always been from January to January, but there is a technical difference in the matter of bookkeeping. While dues have always been due January 1, as stated, there has heretofore been an interval of three months before the fact of payment, or to put it another way, the fact of delinquency, is made of record. In effect, and through the sufferance of county society secretaries, nobody knows whether any given member has paid dues until the county society annual report is filed with the State Secretary. The By-Laws of the State Medical Association state that membership is determined by reference to the annual reports of county society secretaries. In short, members have had from January 1 until April 1 in which to pay dues if their respective county society secretaries were agreeable. The change in the fiscal year makes a difference in the bookkeeping, which may or may not be important to the individual member. It is hoped that membership for 1947 will be rather generally paid for during the month of December. It will help a good deal if that is done, and the earlier payment won't hurt anybody.

Again we make the plea that members help their respective county society secretaries by paying dues voluntarily and without solicitation. It is perhaps appropriate to remind our readers that State Medical Association dues are $20, plus whatever the county society shall charge on its own account. There are other types of membership, intern, honorary, and military. Intern and honorary memberships dues are $4. The regular membership dues, intern, and honorary, include subscription to the JOURNAL and medical defense. Military membership dues are only $1, to cover medical defense. Subscription to the JOURNAL is not included.

The State Secretary has asked that county society secretaries remit dues as fast as they are collected, so that members may receive their membership cards and be listed as members.

CURRENT EDITORIAL COMMENT*

Demerol and Drug Addiction.—Since the dramatic recognition of the seriousness of addiction to cocaine and morphine, in the latter part of the nineteenth century, physicians have recognized the potential addiction properties of many other chemicals, including alcohol, the bromides, barbitals, and chloralhydrate. Many attempts have been made to develop morphine pain relieving drugs without the addiction properties characteristic of morphine itself. The National Research Council appropriated some $50,000 a year for nearly ten years for a coöperative study involving the Chemical Laboratory of the University of Virginia, the Pharmacology Laboratory of the University of Michigan, and a number of clinical investigators, to work on this problem.[2] The effort was later

*This department of the JOURNAL presents editorial comments on current items pertaining to the science, art and practice of medicine, contributed by members of the State Medical Association and scientists closely associated with the medical profession of Texas. Invitation is hereby extended to any member of the State Medical Association of Texas to submit such discussions for this department. The discussions should not be more than 500 words in length.

consolidated in the United States Public Health Service. It was thought that slight chemical modification of the morphine molecule might result in divorcing the addiction properties of morphine from its pain relieving properties. In spite of the vast amount of important scientific information gained from the study, the results, from a practical standpoint, were negligible.

Commercial manufacturing houses have introduced many alleged non-addiction morphine substitutes. One of the earlier ones was "dilaudid." This was claimed on the basis of animal experiments and a few clinical observations to be non-addictive. However, it was soon discovered that, as the number of patients using it increased, cases of addiction appeared.

More recently German chemical concerns developed a morphine derivative called "dolantin" which was later introduced into the United States under the trade name "demerol." This drug was again claimed to be non-addictive, although it was asserted to be as powerfully pain relieving as morphine. Unfortunately, the pain relieving properties of the drug were exuberantly "dekruifed" in *Reader's Digest*. This article provoked severe reaction from the United States narcotic authorities, who reported many cases of addiction which were definitely traceable to the use of the drug.[1]

Physicians now recognize that drug addiction is largely a psychiatric problem. If a person cannot tolerate the environment in which he is forced to live, if he has something to run away from, he may find his "escape" in the use of some drug which will dull his appreciation of the environmental circumstances. Alcohol, morphine, and the central nervous system depressant drugs in general are of this type, and all of them are potentially addiction drugs. It is not likely that any significant central nervous system depressant drug will be found which will be wholly free from addiction properties, at least in the case of a person who is trying to "escape" from the unpleasant conditions of his environment. Physicians will wisely consider the possible factors in the environment of a patient which may lead to a psychiatric or suppressive impulse to "escape" in connection with any proposed continued administration of a central nervous system depressant or pain relieving drug.

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HYPERTENSION

SOME USES AND ABUSES OF THE THIOCYANATES

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The thiocyanates are known to relieve the symptoms and often reduce the blood pressure of certain patients suffering with cardiovascular-renal diseases and their use is being applied more extensively each year, both here and abroad. Both praise and denunciation of the thiocyanates appear in clinical literature,[15] most of which is understood by those experienced in the use of the thiocyanates in vascular disease.[8, 13, 14] Little information on pharmacology of the drug has appeared[5, 9, 10] and much more critical study should be fruitful as indicated by studies published thus far.[6, 7] The carefully controlled individualized dosage necessary to maintain the desired thiocyanate concentration in the body, between 6 and 12 mg., can be directed by the determination of the blood cyanate concentration as published in 1936.[1] That technique of thiocyanate administration and control has gone far to demonstrate the frequent great value of this drug when properly supervised and to avoid certain dangers of overdosage.

In my opinion, T. Izod Bennett recently crystallized the present state of the problem in his address on hypertension before the Royal Society of Medicine[4] by stating that

> "One of the few practical contributions to the therapeutics of hypertension is the potassium thiocyanate treatment. No one has as yet put forward any proof as to how this substance acts. . . . It is perhaps this lack of scientific explanation, together with the risk of toxic effects from overdosage and the necessity for somewhat frequent blood analysis, that has made us slow in employing this treatment on a large scale. But although its action is uncertain and its use requires great care, there is no doubt at all that potassium thiocyanate does sometimes give dramatic results in properly selected cases. . . . I cannot permit the criticism of the overcautious or the scepticism of the ultra-scientific to divert me from the fact that this treatment is today the only treatment we possess to combat a disease which kills some hundred thousand people every year in England and Wales. It is doubtful if thiocyanate therapy will survive, but it will probably disappear not on account of its uncertainties or dangers but because it will be replaced by something more effective."

Personal clinical and experimental observations of thiocyanate therapy for the past eighteen years without a death attributable to the drug finds me in accord with Dr. Bennett, and no doubt a better understanding of the action, use, and contraindications

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will be developed, which will clarify many of the questions discussed today.

Cardiorenal-vascular diseases destroy some 600,000 persons yearly in the United States, and this astounding figure overshadows the relatively small total loss of some 300,000 of our men in four years of the world's greatest war. The complications of hypertension account for this great number of cardiovascular deaths because of ultimate congestive heart failure, coronary occlusions, cerebral vascular accidents, or uremia. A few cases of high blood pressure follow nephritis, urinary tract infections, toxemias of pregnancy, impaired blood supply to the kidneys, or because of adrenal or other tumors such as the pheochromocytomas.[11] A differential diagnosis usually can be made by facilities available in almost all communities.

Obviously, if any condition is found that may lend itself to surgical or any other cure, the administration of nonspecific or palliative treatment is contraindicated, but such cases are few indeed. The largest number of patients with high blood pressure fall into that group commonly called benign or essential hypertension for which there is no specific therapy. But it should be emphasized that reassurance, mental and physical hygiene, weight control, vitamins, endocrine balance, and sedation are points of fundamental general management long used by many physicians, often with high degrees of success. Years of clinical and experimental observations of the thiocyanates in cardiorenal vascular disorders have resulted in knowledge of this additional, useful means of therapy in selected cases, as well as some contraindications or cautions which at times result in abuses of this valuable drug if it is casually employed.[3]

Certain general indications, cautions, and goals, which may be summarized briefly, are kept in mind in our clinic when the thiocyanates are to be used:

1. Plethoric hypertension cases (benign or essential) with distressing symptoms and/or cardiovascular disturbance in whom the red cell pack is usually found to be over 50 per cent (red blood cell count over 5 million) and the sedimentation rate 5 mm. or less. Such blood appears dark and viscid when drawn into a syringe. Continued controlled blood cyanate concentration (8 to 12 mg. per 100 cc.) usually results in a rather prompt relief of cerebral symptoms and often a gradual decrease in the systolic blood pressure of 10 to 20 mm. per week and a much slower effect on the diastolic level. Rarely should the total cyanate dosage exceed 5 grains (.3 Gm.) per day in the beginning months, but as renal thiocyanate clearance improves, the dosage may necessarily be increased to as much as 20 grains per day to maintain an adequate blood thiocyanate concentration with which the desired symptomatic relief and the hypotensive effect are generally associated. During the first three to four months of such therapy, the high cell pack and the low sedimentation rate will change. In fact, sharp drops in blood pressure should be avoided until a sedimentation rate of 15 or above and a hematocrit of 45 or less are obtained because of the danger of cerebral and coronary vessel occlusions.[1, 3] A lined graph represents a summary of a series of carefully controlled plethoric hypertension cases which brings out these interesting relations (fig. 1).

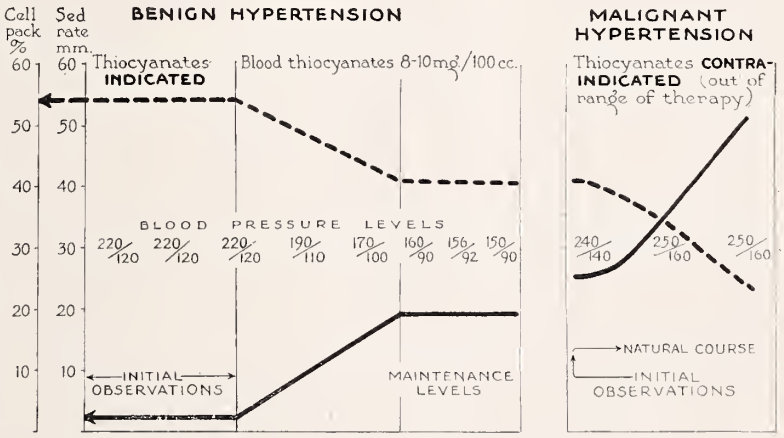

FIG. 1. Graph summarizing a series of carefully controlled plethoric hypertension cases.

The occasional patient may develop a sharp normocytic or slightly microcytic anemia of such degree that the thiocyanates should be stopped. Most patients with blood counts reduced to 3.5 or 4.0 million present no untoward symptoms or findings and they usually feel better with their red blood cell counts about one million below their high control levels. Certainly, many amazing symptoms such as early morning headaches, ringing in the ears, dizziness, blurring of vision, insomnia, nervousness, and constipation are gradually relieved. In general, the goal seems to be a hematocrit reduction to 38 per cent in the female and 40 per cent in the male, and an increase in the sedimentation rate to 15 to 20 mm. in the uncomplicated case of hypertension. Such changes

in the blood constituents or qualities are by no means specific because relief of symptoms and other benefits may be obtained at times in chronic glomerular nephritis with contrary blood findings; such cases will be discussed later.

2. Uncontrolled congestive heart failure in hypertension where continued bed rest, digitalis, and diuretic regimes are insufficient to maintain comfort or capacity for a gainful occupation may be compensated by proper thiocyanate therapy. If the systolic and diastolic pressure may be reduced to levels of 180/100 to 150/90, an occasional patient may recover from a severe and repeated decompensation to return to a surprisingly satisfactory sustained activity. The heart shadows may reduce in size and the abnormal electrocardiogram of the hypertensive patient often may show changes back toward the normal in three to six months after the strain has been reduced. One such patient, age 68, with severe protracted, uncontrollable heart failure who improved after cyanate therapy as reported in 1936[1] (case 3) is still very well and active for his age (81) without cardiac treatment but he has had to continue the cyanate therapy for thirteen years with a blood concentration ranging between 8 and 12 mg.

3. Patients having sympathectomies for their hypertension should be offered controlled thiocyanate therapy if annoying symptoms or other manifestations of an unrelieved hypertension are present. Dr. Loyal Davis and I have reported on certain favorable responses to cyanate therapy in patients after their failure to improve or remain functionally efficient after sympathectomy.[6] Such patients recently reviewed six years after sympathectomy appear surprisingly normal, but they require thiocyanate therapy to remain comfortable and/or free from congestive heart failure. An occasional patient, found to be refractory prior to the operation, responded to the cyanates after a sympathectomy. Such observations are without explanation in man or animal.[7] The empirical use of the drug in these postoperative sufferers seems justified in view of such benefits that may be obtained.

4. Chronic glomerular nephritic patients in whom hypertension with gallop rhythm, nocturnal dyspnea, and congestive failure may obtain symptomatic relief and regain circulatory compensation by similar blood concentrations of the thiocyanates. A reduction of the blood pressure from 220/140 to 120/90 has been observed without any measurable decrease of renal functions or aggravation of the nitrogen retention. In fact, a diuresis and an improved blood chemistry pattern may follow such decreases of the workload on the heart.[2] Thus, embarrassed renal function appears to be no contraindication to cyanate therapy but the reduced renal clearance will necessitate a relatively smaller dosage as the blood concentrations will demonstrate.

A few points in the selection of cases of cardiovascular-renal diseases for treatment together with cautions and controls for administration of the drug go a long way in avoiding unsatisfactory results with thiocyanate therapy.

Hypertension where anemia and a high sedimentation rate exist when first seen usually is not benefited by the thiocyanates. In fact, such cases are usually malignant in nature and their progressive anemia and their general deterioration might be aggravated by the drug although such effects are not easily proved.

Doses over 5 grains (0.3 Gm. sulfocyanate) per day are rarely required during the first month. The smallest amount that will relieve symptoms and bring clinical improvement should be used. The reduction of the blood pressure is of secondary importance but if it does fall, the decrease should be gradual. A transient fatigue or exhaustion which will disappear in four to eight weeks may be noted. Reduction of the blood cyanate level to one-half the fatigue concentration for one month may be desirable. Rarely a patient complains of continued severe exhaustion when the thiocyanates are administered; such patients may be better treated by other means.

3. The blood concentration must be determined at frequent intervals during the early months of thiocyanate therapy. A check of the clinical picture, the blood pressure, and a blood thiocyanate determination are recommended each ten days for the first month, each fifteen to twenty days during the next two to three months, and monthly for the remainder of the year. Long intervals of three to six months are permitted depending upon the clinical course and the patient's experience. The blood concentrations of 8 to 12 mg. per 100 cc. are usually necessary although some patients, especially older women, may require only 4 to 5 mg. Initial large doses and failure to check the blood levels constitute one of the chief concerns of cyanate therapy, but failure to attain and maintain a proper level at times explains a lack of success.

4. Sedatives such as the barbiturates, chloral, and bromides are better omitted during the initial weeks of thiocyanate therapy so that symptoms may not be con-

fused or clouded. They may be resumed later if needed.

5. The thiocyanates should be stopped during febrile periods of infections and prior to surgical procedures, both of which alter blood pressure and the renal excretion of the drug. One exception may be made during a vascular crisis with encephalopathy and acute retinopathy when sympathectomy is contemplated. The thiocyanates, 1 Gm. intravenously each day for two to three days, raising the blood concentration to 5 to 8 mg. per 100 cc., may stop the nausea, vomiting, headaches, and gallop rhythm and a period of calm may be held for one month during which the operation may be performed. The drug should be stopped when toxic manifestations or idiosyncracies such as itching, scaling, dermatitis, mental symptoms, anemia, and undue exhaustion are noted. At times the drug may be renewed after two or three months without recurrence of these untoward effects.

6. A diffuse gradual enlargement of the thyroid[15] rarely acute,[12] may be met, but it will return to normal with .5 to 1 grain of thyroid extract daily. The basal metabolism is rarely depressed more than 5 to 15 per cent and I have never observed advanced symptoms or findings of myxedema. The gland will return to normal proportions in one to two months if the drug is stopped, and the hypertension syndrome will return. The resumption of the thiocyanates usually causes no goiter formation as long as the thyroid extract is administered. Certain patients with bloated faces and exhaustion appearing during thiocyanate therapy are often greatly improved by tonic doses of thyroid substance.

7. Elderly persons with arteriosclerosis should be treated with caution because of occasional rapid decreases of blood pressure which may lead to arterial thrombosis. Such patients often have relatively low diastolic pressures and the blood concentration of thiocyanate may rise very rapidly because of poor clearance;[1, 3] hence initial doses of 3 grains daily with blood cyanate determinations at seven to ten day intervals are indicated until the increment of the blood concentration may be projected. Patients aged 60 to 80 often respond especially well and they are greatly appreciative for being freed of their symptoms of headaches, heart consciousness, vertigo, and visual disturbances.

A few of the indications for the use of the thiocyanates in cardiovascular disease have been stressed. I am eager to emphasize that the relief of symptoms and the general clinical improvement of the patient resulting in a more happy, efficient, and productive member of society is the goal of such treatment. The reduction of the blood pressure is of secondary importance even though such pressure changes often parallel the clinical improvement. Perhaps the greatest abuse of thiocyanate therapy has been its casual administration with an over-emphasis of the reading obtained by the blood pressure machine.

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INFANTILE PARALYSIS RECOVERY INCREASED

Improvement in treatment of infantile paralysis resulting from recent research demonstrating that virus damage to the spinal cord and brain areas is often only temporary means that 3 out of 4 infantile paralysis patients can recover without any handicap, Roland H. Berg, staff member of the National Foundation for Infantile Paralysis, writes in the October, 1946, issue of *Hygeia*. Immediate hospitalization and early and continuous physical therapy to maintain muscles in as healthy a condition as possible until normal nerve impulses return has effected the increased possibility for recovery.

NERVE INJURY FROM PENICILLIN

Penicillin may cause injury to the nerves running to the surface of the body with resultant loss of sensation and muscular power, Comdr. Lawrence C. Kolb and Lieut. Comdr. Seymour J. Gray, both of the Medical Corps of the Naval Reserve, suggest in the October 12 issue of *The Journal of the American Medical Association*. Muscular weakness was observed in 7 patients treated with penicillin injections into the muscles, ten to twenty-one days after the initial injection. The number of injections prior to the symptoms varied from ten to seventy-two. Complete recovery from the neuritis occurred within four months in 5 of the 7 patients.

POSTHYPOGLYCEMIC ENCEPHALOPATHY

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Since 1921 the danger from hypoglycemia has been recognized. Wohlwill in 1928 made the first detailed study of brain changes in a diabetic patient dying from insulin shock, and in the same year Ravid summarized 6 cases of transient hypoglycemic hemiplegias reported in the literature to that date including 1 case of his own. McClenahan and Norris, in the first case of benign tumor of the islands of Langerhans with hypoglycemia proved by antemortem blood studies, reported evidences of meningeal and cerebral irritation on postmortem examination. In 1931, the case of a diabetic patient with hemiplegia for many weeks after hypoglycemia was reported, and one year later Bast, Schmidt, and Sevringhaus reported a case of hypoglycemia with neurologic symptoms persisting for five days after adequate feeding was instituted. Wilder,[19] in 1933, wrote: "A feature about this type of coma (hypoglycemia) that is very characteristic is its rapid termination when glucose is administered—but recovery is less certain, less rapid and less complete, even when sugar is given, the longer it persists. Irreversible changes may then occur in the brain: degeneration of the ganglion cells, or hemorrhages as described by Terbrüggen." Since that time the clinical entity posthypoglycemic encephalopathy has been reported under the headings of various synonyms.[12]

Dameshek, Myerson, and Stephenson[4] have shown that the difference in dextrose content between blood drawn from the carotid artery and the internal jugular vein was greater than that between the brachial artery and the basilic vein. Himwich and others[11] have shown that following the administration of insulin, the difference in the dextrose content between the blood drawn from the brachial artery and the jugular vein usually diminished and that the oxygen utilization and metabolic rate of the brain are decreased during severe hypoglycemia. Gerard[7] has reported that the respiration of the brain, namely, oxygen consumption per unit mass, is about thirty times as intense as that of muscle or nerve. That dextrose is essential in normal utilization of oxygen by brain tissue is usually agreed, and it is further generally agreed that acute anoxia or hypoglycemia affects first the cerebral cortex, next the upper portion of the brain stem, and finally the medulla.

Grayzel[10] reported that rabbits in which hypoglycemia was experimentally produced showed definite central nervous system lesions and that zones of necrobiosis were more noticeable in the pyramidal cells of the third and fifth cortical layers. Other animal experimentation has shown hypoglycemia to produce liquefaction, vacuolization, and homogenization of ganglion cells, marked shrinkage of cytoplasm and nuclei, diminution in number of neurons in various cortical areas, and small microscopic hemorrhages. Baker[3] at first believed that changes found in the ganglion cells on postmortem examination of 3 patients dying after hypoglycemia were caused by postmortem degeneration but in later papers concluded that these were antemortem changes. He subsequently reported extensive brain damage, congestion, hemorrhages, patchy demyelinization, cyst formation, encephalomalacia with necrotic and active proliferation, various degrees of cellular degeneration, and gliosis following hypoglycemia. Similar pathologic observations have been reported by Sahs and Alexander, Kerwin, Weil and others, Root and Styron,[17] Murphy and Purtell,[15] and others. It is generally agreed that it is difficult to distinguish less severe nerve cell changes from postmortem alterations.

Cases of posthypoglycemic encephalopathy have been reported in every age group, as frequently in children as in adults. Rascoff, Beilly, and Jacobi[16] reported a case of hypoglycemia of the newborn with hypertrophy and hyperplasia of the islands of Langerhans, the patient dying thirteen hours after birth from a latent diabetic mother. Although posthypoglycemic encephalopathy, to my knowledge, has not definitely been reported following hypoglycemia of the newborn, it remains a definite possibility to be considered in determining the etiology of mental deficiency states of childhood. Darrow[5] had 2 cases of convulsions and mental deficiency in children following hypoglycemia. A case of transitory hemiplegia associated with hypoglycemia in a diabetic child with congenital heart disease was reported by Fisher.[6] Allan and Crommelin[1] reported the case of a six-year-old diabetic child with an insulin reaction in which the patient was stuporous for three days, followed by hemiplegia, aphasia, and epileptic seizures for fifteen months. The case of an 8-year-old child with idiocy secondary to degenerative lesion of the brain from overdosage of insulin was reported by Wilder.[20] In this case unconsciousness persisted for six weeks, and the mental condition never returned to normal. Anderson[2] had a 7-year-old diabetic patient with a severe behavior disorder following hypogly-

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cemia and a 13-year-old diabetic patient with an insulin reaction followed by four days of coma and then gross dementia which gradually but only partially improved during the next fifteen months. Fenz and Kogerer reported the case of a 16-year-old boy in which a severe insulin reaction was followed for a fortnight by a syndrome characterized by negativism, catalepsy, grimacing, and motor restlessness, with subsequent improvement but persistence of apathy and dullness after four months. Terplan[18] also reported the case of a 16-year-old diabetic boy who did not regain consciousness for three days after insulin shock, the blood sugar levels being normal during this three-day interval. In this case postmortem examination showed extreme edema of the brain and destruction of the ganglion cells.

Similar cases have been reported in adults, not only in diabetes,[13] but also following the Sakel form of shock therapy for schizophrenia,[8] and in cases of pancreatic adenoma.[14] The case reported by Root and Styron[17] in which the patient remained in a comatose state for twenty-three days and finally died with terminal bronchopneumonia and sepsis is similar to the second case reported by Jones.[12] A similar case with coma for seventeen days terminating in death was reported by Lawrence and others. Cases with Korsakoff's syndrome persisting for several months after hypoglycemic shock have been seen. Lindsay and others have also reported a case in which a combination of hypoglycemia and arteriosclerosis seemed to cause the cerebral damage. Murphy and Purtell[15] reviewed 26 cases of hypoglycemia with cerebral damage and concluded that the most common aftermath was profound mental and personality damage, at times extensive enough to leave the patient with the intellectual level of idiocy, and at times resulting in mental retardation, apathy, and dullness, progressing to true psychoses. Parkinsonism, aphasia, persistent hemiplegias, and objective neurologic changes have persisted for months.

Goldman[9] reported that 17 per cent of 108 patients given a total of 5,882 insulin shock treatments (Sakel therapy) had posthypoglycemic coma which persisted for some time after the blood sugar levels became normal. He found that the predisposing causes were hard to detect, but that usually after deep hypoglycemic shock and moderately prolonged shock for five or six hours the posthypoglycemic coma was more likely to occur. He concluded: "Coma persisting after cessation of hypoglycemia is an entity in itself and related only in a secondary sense to the hypoglycemia." Thus, in case 1 reported by Jones[12] a state of mental confusion and change in personality, apparently clinical persistence of hypoglycemia, remained for forty-eight hours with high blood sugar levels. The clinical picture was not due to persistent hypoglycemia but to transient cerebral damage caused by the preceding hypoglycemia. In the second case reported by Jones apparent idiocy, aphasia, and neurologic changes remained for eighteen days after the blood sugar returned to normal or high levels. Root[17] pointed out that irreversible cerebral changes will occur sooner or later in hypoglycemia if the hypoglycemia is not properly treated, and stated that: "therefore where unconsciousness occurs, particularly when insulin has been given to a patient already suffering from hypoglycemia, we find it advisable to give intravenous 10 per cent glucose until the patient is conscious."

CONCLUSIONS

Posthypoglycemic encephalopathy is a definite clinical entity reported with increasing frequency in the literature. It is characterized by persistent personality, mental, and neurologic changes following hypoglycemia for variable periods of time. The physiologic and pathologic changes responsible for the clinical behavior are briefly discussed.

Members of the medical profession should be aware of this very serious complication of hypoglycemia and combat any prolonged low blood sugar level vigorously.

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Medical Arts Bldg.

ABSTRACT OF DISCUSSION

Dr. Gladys J. Fashena, Dallas: Dr. Jones has presented an interesting and valuable paper. All of us have known that oxygen is necessary for the cellular integrity of the central nervous system, and that lack of this substance, even for a very short time, will produce cellular damage. Most of us have not appreciated the fact that lack of glucose, the substrate which is oxidized, will produce the same result, nor have we been made sufficiently aware of the tremendous need of brain tissue for glucose as compared with muscle tissue, for example. Apparently the only fuel which the brain can burn is glucose. Peripheral tissues, however, can burn other metabolites, such as fatty acids and ketone bodies, directly.

All of us have probably encountered instances of hypoglycemic encephalopathy, but have been unaware of the mechanisms involved. This entity will probably be of importance, not only in connection with diabetic insulin reactions, but also in connection with other conditions known to produce hypoglycemia, such as hepatic disease, hyperinsulinism, and other forms of pancreatic disease.

VAN METER PRIZE OFFERED FOR 1947

The American Association for the Study of Goiter again offers the Van Meter Prize Award of $300 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the Association in Atlanta, Ga., April 3-5, 1947, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English; and a typewritten double spaced copy sent to the corresponding secretary, Dr. T. C. Davison, 207 Doctors Building, Atlanta 3, Ga., not later than January 1, 1947.

A place will be reserved on the program of the annual meeting for presentation of the prize award essay by the author if it is possible for him to attend. The essay will be published in the Annual Proceedings of the Association. This will not prevent its further publication, however, in any journal selected by the author.

To prevent errors in diagnosis, it should be a routine practice not to make a diagnosis of pneumonia, bronchitis, asthma, pleurisy, chest cold, catarrhal fever, or grippe without first considering the possibility of tuberculosis.—I. D. Bobrowitz, M. D., and Ralph E. Dwork, M. D., New England J. Med., Jan. 11, 1946.

SYMPATHECTOMY FOR CERTAIN FORMS OF PERIPHERAL VASCULAR DISEASE

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Until comparatively recent years the treatment of peripheral vascular disease was, in general, somewhat unsatisfactory. The probable explanation for the dilemma was, as Ochsner and DeBakey[15] have already pointed out, that most physicians associated gangrene and peripheral vascular disease too nearly or entirely together. It was not generally appreciated that gangrene represented the terminal stage of a peripheral vascular phenomenon. It has only been since the pathologic physiology of the circulation in this group of diseases has been better understood and methods to differentiate between functional states and organic occlusion have developed that a rational therapy could be instituted.

In all conditions where peripheral vascular disturbances are present, it is necessary to determine if the diminution in the caliber of the vessel is functional or organic in origin or whether it is due to both of these conditions. It is highly probable that both conditions can produce a narrowing in the caliber of the vessel which results in circulatory insufficiency of the extremity which causes the symptoms.

Probably the most satisfactory clinical classification of peripheral vascular disease is that of Ochsner and DeBakey[14] which is based on anatomic and functional disturbances in the vessels: (1) vasospastic functional disease, (2) vasospastic organic disease, and (3) organic degenerative disease.

If the symptoms are caused by lack of a sufficient blood supply to the extremity, it is necessary that the basis of all therapy be directed towards the increase of blood supply to the parts affected. It would seem under these circumstances that any treatment based on other factors is without a rational basis. Since these facts are apparently understood, numerous methods to determine the amount of vasospasm present,[7, 9, 13, 19] the degree of obliterative occlusion present, and the amount of vasospasm present in cases of organic occlusion have been developed; along with these,[5] numerous methods to increase the circulation have also been developed.

It is not possible in this paper to discuss all

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of the various procedures that have been used, but only the ones we have found of value and those practical in our hands will be mentioned.

When the vasospasm is released by interrupting the vasospastic control to the vessels of the extremity, there is a corresponding increase in the arterial circulation which increases the cutaneous heat radiations. We believe that the best index to this heat increase is by palmar palpation before and after operation. The method we have used, however, to determine the increased temperature is with a thermocouple or dermatherm. This probably affords a more accurate determination if, as should be the case in all laboratory procedures, it is carefully executed. The patient should be placed in a room with a constant temperature not greater than 70 F., and the humidity in the room should remain constant. The vasospasm, if present, is relieved by injecting the stellate and first, second, and third thoracic ganglia in case an upper extremity is involved, or the first, second, third, and fourth lumbar ganglia in the case of a lower extremity, with a 1 per cent procaine solution. The temperatures of the extremity, before and after the injections, are recorded with the dermatherm.

This method determines only the increase in the vascularity in the most peripheral part of the extremity. Ochsner and DeBakey,[15] De Takats,[8] and others[4] have found the recording oscillometer of value in determining the increase in the pulsations of the larger vessels of the muscles, but this method is not accurate to determine the pulsations in terminal ends of the digits. However, the pulsations of the digits can be recorded with a plethysmograph. Both of these latter tests are made in conjunction with the dermatherm tests before and after a paravertebral block has been done with a 1 per cent procaine solution. There have been no ill effects[3] from paravertebral blocks in several hundred cases for diagnosis and in certain forms of treatment such as thrombophlebitis and arterial occlusion.

There are a number of factors that generally influence the diagnosis and prognosis in a case of peripheral vascular disease. It seems reasonably clear that the younger the person is with peripheral vascular disease, the more likely the disease is to have a vasospastic basis. The most common factors that precipitate or influence spasticity are exposure to cold, probably the use of tobacco, and emotional stress.

The various vasospastic and allied conditions for which we have used sympathectomy to advantage will be discussed. It is impossible to go into all details at this time, for each condition would compose a long paper.

RAYNAUD'S DISEASE

Raynaud's disease is representative of a functional vasospastic condition. It is more common in women, as shown by Hines and Christeen of the Mayo Clinic, who found 79 per cent of their cases to be in women. People in the third decade are more frequently attacked; exposure to cold and emotional strain are frequent offenders in precipitating an attack.

The symptoms of Raynaud's disease[17] begin with intermittent changes in the color of an extremity. These color changes are not always uniformly symmetrical nor are they always the same on the same extremity. They

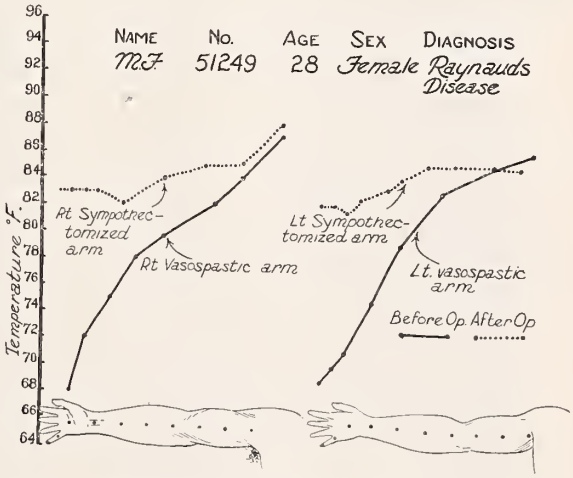

FIG. 1. Graph showing temperature readings of the upper extremities before and after bilaterial thoracic sympathectomy in a white woman, age 28, with Raynaud's disease.

vary between blanching and cyanosis. When the latter is present, coldness is also present, giving a numb effect. When the extremity is warmed, a burning, stinging pain develops. As the disease progresses, a dull pain becomes associated with the numbness. The patient is often unable to perform any delicate, manipulative work. The terminal or end arteries are affected in this disease; consequently pulsations in the larger vessels are present. If the disease continues to progress, gangrenous changes develop in the terminal ends of the digits.

CASE REPORTS

CASE 1.—*Raynaud's disease with moderate structural changes in the arteries.* Miss J. M., age 31, occupation stenographer, developed Raynaud's syndrome nine years previously. At intervals her feet during the winter months became cold and clammy. It was necessary that she wear woolen hose during the winter. The symptoms disappeared during the summer unless she became emotionally upset. The condition gradually increased until her feet were cyanosed most of the time; also she had severe burning and a dull ache and was forced to remain indoors

during cold weather or suffer extremely. Small ulcers developed on the second and third toes of the left foot and the second, third, and fourth toes of the right foot.

Examination revealed a well developed, white woman of the nervous type. Radial pulses, and anterior and posterior tibial pulses were full and equal. Blood pressure was 120/80. The feet, when dependent, were cyanosed, cold, and clammy. A bilateral lumbar sympathetic block was done, using 1 per cent procaine solution. One hour later there was marked increase in the skin temperature of the feet and ankles. The skin was dry. A bilateral lumbar sympathectomy was done at ten-day intervals. At the end of two months, the patient returned to her position with no further trouble. Lesions on her toes had completely healed.

CASE 2.—*Raynaud's disease without structural changes of the arteries.* E. G., age 34, a white man, developed symptoms of Raynaud's disease, which were more pronounced in the left foot, three years previously. The disease had progressed to the point of practically incapacitating the patient.

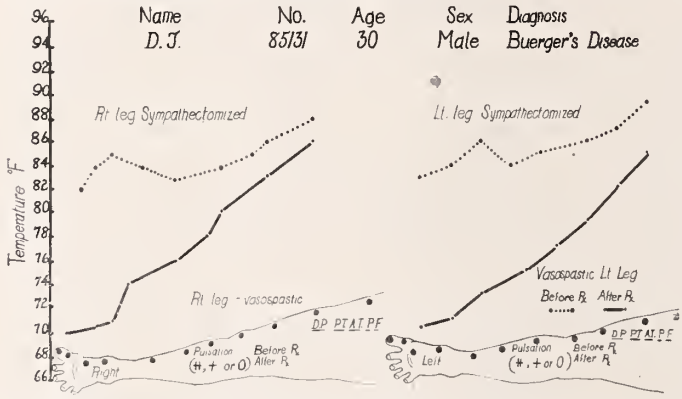

FIG. 2. Graph showing temperature readings of the lower extremities before and after bilateral lumbar sympathectomy in a man, age 30, with Buerger's disease.

Examination showed a well developed, well nourished, white Gentile. All examinations were normal; pulses in wrists and ankles were normal. The feet, toes, and lower legs were cyanosed with cyanosis more pronounced on the left side.

After a bilateral lumbar sympathetic block with 1 per cent procaine solution the skin of the feet and toes became warm and dry. A left lumbar sympathectomy was done resulting in excellent recovery. The patient returned three years later with such marked involvement of the right foot that he requested a right lumbar sympathectomy be done. At that time he was beginning to have involvment of both hands. He had a good convalescence following a right lumbar sympathectomy. In all probability the disease will progress in his hands to the extent that it will necessitate his having a bilateral cervico-thoracic sympathectomy.

THROMBO-ANGIITIS OBLITERANS

In contrast to Raynaud's disease, in the condition of thrombo-angiitis obliterans or Buerger's disease males are more frequently attacked than females. The average age[17] when a large series of cases are analyzed is about 35 years. There are numerous reports of its presence[6] in the "teens."

There is much disagreement regarding the specific etiology of this disease, however; most authorities believe[17, 18] that the use of tobacco plays a definite role, while others believe that toxic infection often precedes the initial attack. Several have shown that the disease will progress from one limb to the other and become intensified in the involved limbs if the use of tobacco is continued. Lewis is of the opinion that the disease is produced by what he termed a "local fault"[12] in the walls of the digital arteries. He stated that he can precipitate an attack after sympathetic innervation has been interrupted.

In Buerger's disease the vessel walls are thickened, and late in the disease there may be extensive scarring which involves the arteries, veins, and nerves in one mass. The primary arteries are often occluded with thrombi, and there is connective tissue proliferation with thickening of the intima. If the thrombus becomes organized and canalization or resolution takes place, the limb may not suffer too much from a lack of circulation. However, if this does not occur, the nutrition of the tissues will have to depend on development of the collaterals. It is in this role that sympathectomy should be of benefit.

The lower extremities are more frequently involved than the upper, and very often at first only one extremity will be affected. The symptoms are most frequently noted following exercise, and since the primary as well as the secondary vessels may be affected, there will be intermittent claudication resulting from an insufficient blood supply. The color changes are noted with posture changes. When the extremity is elevated for several minutes there is pallor and blanching; when it remains dependent there is cyanosis and rubor. Pulsations in the peripheral vessels may be weak, or in cases that have progressed sufficiently they may be entirely absent. At first pain is associated only with exercise. Later it becomes continuous and trophic changes take place ranging from ulceration to gangrene requiring amputation. Aycock and Gundry[2] have divided the disease into four groups, based on the severity of the disease and rate of progress. The cases vary from quite mild ones, indicated by fatigability of the muscles of the affected extremity, coldness, and minor color changes evident during changes in posture, to the fourth group, which develops very rapidly with excruciating pain of claudication, terminating in massive gangrene in a period of one to four months.

Sympathectomy will relieve any spasm in

these cases as well as in cases of arteriosclerosis, and in doing so probably assists in canalization and absorption of the organized thrombus and also in the hopeful development of the collaterals. It is in this group of cases that the results are better manifested after a period of months, apparently because of the factors enumerated above.

CASE 3.—*Buerger's Disease, Grade 2.* D. T., a white Gentile man, 28 years of age, became ill while in the service eighteen months previously. He was discharged with the diagnosis Buerger's disease. He experienced pain in the calf muscles on walking. For the past year he had been treated for rheumatic fever and rheumatism in his feet. The condition was much more severe during cold weather. He had been unable to work as an automobile mechanic for the past six months because of pain in his feet and legs. He smoked thirty cigarets daily.

Examination resulted negatively to the lower extremities, including the heart. Blood pressure was 120/80. Pulsations in anterior and posterior tibial arteries of both feet were very weak. When the feet were dependent both were cyanosed, but they developed pallor when elevated. The skin was cold and moist. Following bilateral lumbar block with 1 per cent procaine solution, both feet became warm and dry and pulsations in the vessels were good. Good moderate elevation in the skin temperature was noted with dermatherm.

Bilateral lumbar sympathectomy was done at ten day intervals. The patient was examined six months later; he had returned to work and suffered no symptoms. His feet were warm and dry.

CASE 4.—*Buerger's disease advanced, amputation of one extremity.* H. W., a white man, Gentile, 38 years of age, occupation electrician, three years previously developed claudication in the calf muscles of both legs. His feet became cold and cyanosed on exertion. He had to sleep in woolen socks. He smoked two packages of cigarets daily. Six weeks before admission to the hospital the patient developed gangrene in the toes of his left foot. The left foot was amputated June 1, 1945. Later it was necessary to amputate through the lower third of the left thigh. The stump did not heal and remained extremely tender and painful. Buerger's disease was also present in the right lower extremity with poor pulsation in the arteries.

A lumbar sympathetic block using 1 per cent procaine solution was done. Good results were obtained in that the foot became warmer and pulsation in the vessels was improved. A bilateral lumbar sympathectomy was done on the left side first, followed three weeks later by the right side. Immediately following the sympathectomy the stump healed and the tenderness and pain disappeared. The right foot became warmer and dry with good pulsation in the vessels. Eight months later the patient was reexamined, showing the right leg to be in good condition, and the left stump produced no further difficulty.

FIG. 3. Photographs of lower extremities in a case of chronic ulceration with lymphedema, before and after bilateral lumbar sympathectomy.

We do not consider that gangliectomy will cure all unfortunate persons in the progressive stages of the disease, but we do believe that this procedure will at least temporarily relieve the symptoms and probably prolong the period before amputation is necessary.

ARTERIOSCLEROTIC CHANGES SIMULATING BUERGER'S DISEASE

There is an older group of patients with arteriosclerotic changes[2, 18] in their lower extremities which produce symptoms that simulate Buerger's disease. In these cases if

there is a moderate degree of spasm present the patient will receive benefit from sympathectomy provided there has not been too much damage to the arteries.

CASE 5.—W. C., a white 52 year old insurance executive, stated that for the past three years he had claudication on exertion, and that he could walk only one or two blocks before developing severe calf muscle pains. His feet were cold and moist.

Examination revealed a normal heart and a blood pressure of 168/96. Albumin in the urine was one plus. There were poor pulsations in the arteries of both feet, and pallor when the feet were elevated, with moderate cyanosis when dependent. Bilateral lumbar sympathetic block using 1 per cent procaine solution was done. There was a moderate increase in skin temperature as recorded with the dermatherm, and the feet were dry and pulsations in the arteries increased.

A bilateral lumbar sympathectomy was done at twenty-one day intervals. Moderate improvement in symptoms was achieved immediately. However, it did not reach its maximum for six months, at which time the patient became practically symptom free. It was probable that at that time the maximum development of the collateral circulation occurred.

CASE 6.—*Arteriosclerosis with diabetic gangrene.* C. L., a white farmer, admitted to the hospital July 27, 1945, was known to have had diabetes for several years. For the past year he had had claudication pains in his calf muscles on exertion. Three weeks before admission to the hospital, he developed pain in the toes of his left foot. Upon admission to the hospital, there was gangrene of the second, third, and fourth toes of the left foot. Both feet were cyanosed when dependent. Pulsations were poor in the arteries of the feet. The affected toes were amputated. The wounds were slow to heal, although the diabetes was controlled. A bilateral lumbar block using procaine solution was done. There was a substantial increase in the skin temperature as determined by the use of the dermatherm; also the feet were dry and the pulsations in the arteries were stronger. A bilateral lumbar sympathectomy was done, the first on the left leg, followed two weeks later on the right. The left foot began to heal immediately after the sympathectomy. The patient was discharged on September 28 in good condition. When he was reexamined at three and six months intervals, there were no further gross symptoms of vascular deficiency of the lower extremities. The patient was working every day.

Frostbite often results in a vascular disturbance of the extremity. If severe, it may result in gangrene of a major part of the extremity. If not so severe, there may be excessive vasospasm with partial invalidism of the patient. If the patient is seen immediately, lumbar sympathetic block using procaine and bromsalizol will, we believe, frequently prevent gangrene. If there are residual symptoms, lumbar sympathectomy will be of definite benefit.

CASE 7.—*Frostbite with gangrene.* A white man, 42 years of age, was admitted to the hospital December 23, 1945. He stated he had been drunk for a week and had slept in an automobile for thirty-six hours. He noticed his feet were asleep afterward, and they soon developed a burning, painful feeling. About forty-eight hours before admission to the hospital the toes on both feet began to turn dark. Upon his admission frostbite gangrene involved the toes and half of both feet. Lumbar sympathetic blocks were done at intervals using procaine and bromsalizol. There was improvement, but on January 11, 1946, it was necessary to amputate parts of all ten toes. There was poor healing of the wounds; the feet were cool and cyanotic. On January 21 and February 4 lumbar sympathectomies were done. At the last sympathectomy it was necessary to amputate all of the fourth toe of the right foot. There was rapid healing following the sympathectomies with good pulsations in the arteries of the feet. If the patient had been seen immediately and had had lumbar sympathetic blocks done, amputations would probably not have been necessary. Further observations and study should be done in order to justify these conclusions.

We believe patients with chronic lymphedema and ulceration of the lower extremities will be relieved if there is marked vasospasm present.

CASE 8.—F. M., a white man, 55 years of age, occupation cook, was admitted to the hospital October 19, 1945. The patient said he had had swollen feet for two to three years with recurrent "bouts" of moist eczema or chronic ulceration. Rest in bed at first would relieve the condition. The patient also had claudication when he would walk three or four blocks.

Examination showed the heart normal and the blood pressure 140/90. Urine and other laboratory specimens were normal. There was an ulcerative dermatitis of both lower extremities with marked edema, cyanosis, and when they were allowed to be dependent poor pulsations in the anterior and posterior tibial arteries. Various medical measures were used without any marked response. Bilateral lumbar sympathetic block with procaine solution gave satisfactory response. On December 10 and January 10 lumbar sympathectomies were done. The patient was discharged February 1 completely relieved. Subsequent examinations revealed complete disappearance of the edema, the ulceration, and the claudication.

In the past a large percentage of patients with thrombophlebitis[11] even after treatment continued to have a large, swollen extremity that was very prone to develop slow healing, trophic ulcers. Ochsner and DeBakey found these patients to have marked fibrosis and vasospasm. Sympathectomy will frequently relieve them to a marked degree.

CASE 9.—C. A. S., a 38 year old white salesman, was admitted to the hospital January 8, 1946. The patient three years previously received a Pott's fracture of the right leg and developed a severe thrombophlebitis during the convalescent period, necessitating removal of the cast. The fracture healed, but since that time the leg had remained swollen, painful, cold, and moist. During the past three months it had been so painful, he had been unable to work.

Upon examination the heart was normal and blood pressure was 120/80. Laboratory tests were normal. The right leg was swollen from the toes to the knee. A large trophic ulcer was present on the anterior surface. When dependent the right leg was cyanosed with poor pulsations in the arteries. A right lumbar block was done using 1 per cent procaine solution. The foot became warm and dry with an increase in the pulsations of the vessels. A right lumbar sympathectomy was done. When the patient was discharged from the hospital on January 23, the foot was warm and dry, the ulcer had healed, and the edema had disappeared. Recent examination

revealed that there was marked improvement with very little edema at the end of the day.

HYPERHIDROSIS OF NERVOUS ORIGIN

Excessive sweating of the hands and feet is occasionally encountered. It is of nervous origin caused by overactivity of the sympathetic nervous system. It may also be noticed in Raynaud's disease, but to a minor degree. Frequently the hands or feet, or in some cases both, are so involved that the patient is practically incapacitated. The involved limbs, in addition to being constantly wet, are cold. Several authorities[1, 2] have made worth-while contributions to this cause. The treatment in the more severe cases is sympathectomy, which will give permanent cure.

Case 10.—W. C. E., a white, 37 year old farmer, stated that for the past twenty years he had had excessive sweating of his hands and feet. It was necessary for him to wear cotton gloves because his hands would stick to everything he touched. Also, he would have to change his hose several times daily, and he could often pour sweat out of his shoes. During the winter months this caused him to have recurrent colds. Various types of medical measures were tried, including 5 per cent formalin which caused maceration and dermatitis, but with little result. Roentgen therapy was used with little beneficial result.

An examination was entirely negative except for excessive sweating of the hands and feet. A bilateral lumbar block using 1 per cent procaine solution almost relieved the sweating in the feet for forty-eight hours. A bilateral lumbar sympathectomy (removing the second and third lumbar ganglia) was done in stages at one month intervals. The sweating was completely relieved. The feet were warm and dry. A bilateral thoracic block (second, third, and fourth thoracic) using 1 per cent procaine and alcohol, partially relieved the hands.

Various operative techniques have been developed during the past twenty years for sympathectomy of the upper and lower extremities. The technique we use for the lower extremity was that developed by Flothow,[10] Pearl,[16] and Atlas. It is an anterolateral muscle splitting extraperitoneal approach to the lumbar sympathetic chain. The first, second, and third lumbar ganglia can be readily removed. However, removal of the second and third ganglia suffices in most cases. It is contended by some that after removal of the first lumbar ganglia the power of ejaculation is lost by the male, but this is contested by De Takats. There is no disturbance in libido or orgasm.

The technique used to sympathectomize the upper extremity is that developed by Smithwick[20] and consists of removing the first, second, and third thoracic ganglia through a posterior approach. Intratracheal anesthesia should be used with this technique.

If the patient is carefully evaluated before operation and a careful technique followed, there should be marked permanent improvement in the circulation of the extremity, which will be warm and dry.

CONCLUSIONS

The above presentation is not conclusive, but based on our observations it serves as a scaffold for future study. We will welcome constructive criticism and suggestions in what we believe will prove beneficial to a number of ill persons both young and old, particularly the latter group.

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ABSTRACT OF DISCUSSION

Dr. James Greenwood, Houston:—We are fortunate in being able to hear this fine paper, since so little work of its kind has been done in this particular locality. At one time it was my feeling that these conditions were quite rare in the south, but the work of Ochsner and his group in New Orleans would indicate that this is not the case. During the past year I have seen 10 or 12 advanced cases of peripheral vascular disease with imperceptible pulse in the dorsalis pedis arteries. All of these patients gave a history extending over some years, and sympathetic block produced only slight improvement of symptoms: slight warming of the feet, improvement in color, and some lengthening of the walking distance. Diagnosis should have been possible five or ten years ago when sympathectomy would have been likely to succeed.

I would be grateful if Dr. Hendrick would give the exact criteria for surgery, particularly with

regard to age of the patient, degree of peripheral arteriosclerosis, and the amount of response to sympathetic block needed to make one feel sure that surgery is worth while.

Since he has mentioned the effect of sympathectomy in hyperhidrosis I would like to ask Dr. Hendrick if he has had any experience with this operation for causalgia and phantom limb pain. Also does he have any difficulty in getting his patients with vascular spasm to stop smoking?

In regard to operative technique, it was my understanding that removal of the thoracic ganglia, unlike removal of the lumbar ganglia, produced a postganglionic sympathectomy with the result that benefits were not sustained. In 1936, Smithwick reported his modified dorsal sympathectomy for vascular spasm of the upper extremity in *Annals of Surgery*. In this operation the thoracic chain was sectioned below the third ganglion and the gray and white rami to the second and third ganglia were sectioned. Later both ganglia were covered with a silk cylinder and the end of the chain drawn up into the spinal muscles to prevent regeneration. I would like to ask Dr. Hendrick whether he uses this procedure and whether or not he feels that it is necessary.

Few papers could have been more timely for this section of the country, and I feel that all should be grateful to Dr. Hendrick for bringing it to us.

Dr. Hendrick, closing: Patients with peripheral vascular disease are seen equally throughout the country. However, in certain types such as Raynaud's and Buerger's disease, the symptoms are more pronounced when the weather is very cold. If this group of patients is to be relieved and gangrene, amputation, and chronic invalidism are to be prevented, it is necessary that an accurate diagnosis be made early and appropriate sympathetic surgery done before extensive damage has taken place.

If a relatively satisfactory response to a sympathetic block in patients with peripheral arteriosclerosis obliterans can be obtained as manifested by a warmer, dry foot, we believe that sympathectomy will be of definite benefit, as it will assist in the development of the collateral circulation.

For several years we have used sympathectomy for causalgic states, pain of a phantom limb, and certain types of osteoporosis. If the patients with causalgic states are sympathectomized before extensive damage has taken place in the skin, the results are more gratifying. This will be discussed more extensively in a paper this fall before the Southern Medical Association.

It is our belief that patients with chronic obliterative arterial disease should not smoke. We explain to them that if they expect to keep their extremities they must give up smoking; that they cannot have both.

The sympathectomy used for the upper extremity is that developed by Smithwick and reported in the *Annals of Surgery*. By using that type of sympathectomy there is less likelihood of a regeneration.

ANNIVERSARY OF INSULIN DISCOVERY

Twenty-five years ago, on November 14, 1921, Banting and Best, workers at the University of Toronto, reported for the first time the isolation of the substance of the pancreas that had the faculty of lowering the blood sugar and enabling a depancreatized dog to survive for an indefinite period. The first two papers covering the results of their work—the discovery of insulin—were published the following February and May. A celebration under the joint auspices of the University of Toronto and the American Diabetes Association is being held this year to commemorate that discovery.—J. A. M. A., Sept. 14, 1946.

INTRAVASCULAR CLOTTING IN RELATION TO POSTOPERATIVE PULMONARY EMBOLISM

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During the past few years a massive literature has accumulated relating to venous thrombosis. From this literature the practicing surgeon receives varied and sometimes startling advice. A group of the more extreme proponents of early ambulation in the postoperative period will hardly approve if he considers any operation an indication for temporary bed rest. Others report such large numbers of prophylactic femoral vein ligations that he becomes suspicious that this procedure is being performed on inadequate indication. His personal experience with massive pulmonary embolism may have been limited to a few cases but in these the results probably were disastrous. He dreads pulmonary embolism and wants to avoid it but is at a loss in deciding how far to go in this effort. His quandary is shared by the majority of thoughtful surgeons, for there is still great lack of agreement as to the proper and sensible course.

For several years it has been stated that intravascular thrombosis is divisible into two broad types, one inflammatory in origin and the other a spontaneous coagulation. There is some reason to doubt that this classification is entirely sound. One encounters frequent suggestion that the inflamed variety often represents a later stage of the silent one. However, a working classification is useful, and I believe one can afford to agree that at the time thrombosis is discovered it is usually sound to select a form of management based on the presence or absence of inflammation, since inflammation denotes adhesion and an adherent clot is not apt to float away to the lung.

In the inflammatory type—*thrombophlebitis*—an inflamed vein intima is the important factor. The intimal inflammation invites a deposition of platelets and fibrin, and occlusive thrombosis follows. The platelets and fibrin thus coat the resulting clot so that it is a "white clot" and they assure its early attachment to the vein lining. In view of this attachment embolism is unlikely unless the inflammation progresses to actual suppuration when small fragments of liquefied clot may float away to establish metastatic infectious foci in other regions. Short of suppuration, inflammatory signs are ordinarily an assurance that there is little danger of embolism. Actually the chief threat of em-

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bolism in thrombophlebitis appears to lie in danger that the immobilization of the extremities so generally a part of the management of that disease may invite occurrence of another type of clotting in normal veins elsewhere in the same or opposite extremity. This second type of thrombosis is generally referred to as *phlebothrombosis* or "bland" thrombosis and it is with it that a discussion of the dangers of embolism is chiefly concerned.

Phlebothrombosis refers to spontaneous clotting in a theretofore normal vein. The thrombus is a red clot as when spilled blood coagulates. It tends to propagate itself proximally in the venous channel and at each level remains at least for a time nonadherent so that the entire clot or any portion of it may momentarily come loose to float up the cava and enter the right section of the heart and its pulmonary orifices. This then is the clot of massive pulmonary embolism.

In thrombophlebitis the signs of inflammation of the vein ordinarily make the diagnosis simple. In phlebothrombosis, on the contrary, the process is relatively silent and often passes unnoticed. Careful examination is required to elicit a slight tenderness and swelling in a given venous area. Tensing of the muscles of the region may give discomfort as in Homan's sign of calf pain elicited by dorsiflexion of the foot in phlebothrombosis of the calf. Since local and constitutional reaction is minimal the process will be overlooked unless a close examination is made. This emphasizes the importance of routine examination of the lower extremities in bedfast patients.

Phlebothrombosis, or spontaneous intravascular coagulation, presupposes not only an abnormal tendency for the blood to clot but also a degree of venous stasis which permits clotting to be initiated. The newer ideas as to the areas of stasis in which thrombosis commonly originates have been reviewed by Homans[6]. The former conception was that in "milk leg" or iliofemoral thrombosis the clotting began in the iliac vein and progressed distally. The present conception is that the thrombosis has a peripheral origin and that clots in the femoral or iliac veins represent a central propagation from the veins of the leg. Autopsy studies indicate that whereas thrombosis sometimes originates in plantar veins, saphenous veins, or pelvic veins, in the great majority of instances it originates in the deep veins of the calf.

Debility from carcinoma or other cause invites venous stasis and thrombosis as does the natural immobility of the critically ill. Any abnormal concentration of the circulating blood increases its viscosity and favors stagnation and thrombosis. The thromboses of polycythemia are examples of this effect. Shock, dehydration, and exposure to cold cause blood concentration and circulatory retardation, and thrombosis is particularly favored if such patients are permitted to lie immobile for many hours. Slowed circulation from shock, dehydration, and exposure to cold, with immobility during transportation, probably played a part in initiating thrombosis in certain battle casualties in the European theater where massive pulmonary embolism was encountered in an age group ordinarily thought relatively immune. Perhaps soft tissue contusion from blast was an additional factor in some of these wounded.

Obviously any mechanical factor which promotes local venous stasis favors thrombosis. Since intravascular clotting occurs most frequently in the lower extremities, factors which commonly operate to delay venous return from this area are particularly important. It is in the lower extremities that the deleterious circulatory effects of prolonged bed rest may first appear and it is generally stated that the common denominator of cases of calf vein thrombosis is that the patients all have been subjected to the abuses of bed rest. Several mechanical factors aggravate the effect of rest in bed. (1) Lack of active motions of the extremities permits venous stasis to develop. (2) Increased abdominal pressure flattens veins to decrease venous return. Thus abdominal distention or compression by binders may favor thrombosis, as may pregnancy, bladder distention, or other tumors. (3) Decreased respiratory movement retards venous return from the lower extremities. (4) de Takats and Fowler[3] directed attention to the harmful mechanical effects which may result from the customary Fowler's position. They pointed out the tendency for this posture to promote venous stasis in the pelvis, and they particularly opposed flexion of the knees over any form of popliteal support, stating that this converts the bend in the popliteal vein into an acute fold which is actually obstructive.

To minimize the risk of intravascular thrombosis it is necessary both to correct shock, dehydration, and other influences which increase the coagulability of the blood and to avoid measures which favor a retarded venous return. One need not be an enthusiast for the early ambulation of major postoperative cases to grant that bed rest has commonly been prolonged unduly to its abuse (Burch[1]). Many surgeons feel that the principle of early ambulation can be carried to a dangerous extreme. However, it is becoming increasingly clear that with many of

the less critical operations patients can be on their feet several times daily from the start and if caution is used the patient should benefit by such management. In many leading clinics it has become the policy to have patients walking within twenty-four hours after herniorrhaphy and appendectomy and to encourage it after more major operations such as cholecystectomy and gastrectomy (Elman and Akin[5]). In ambulation the patient can still guard himself against postures and strains which are painful and it is becoming the general belief that movements which are within the bounds of comfort seldom injure wounds. Sudden increases in tension which come as a surprise, as in sneezing or coughing, are a much greater threat to wounds than is careful walking. Furthermore, as Singleton[12] has shown, if incisions are planned so as to split muscle and fascial layers in the direction of tension there is little likelihood of disruption occurring even from sudden movements.

When early ambulation appears unwise certain alternate measures are available and particularly important. The patient must turn or be turned. Deep breathing exercises must be practiced. Especially is attention directed to the value of exercising the extremities of bed patients. Periodic contraction of the calf muscles overcomes venous stasis and propels blood toward the heart. Such exercises are much more apt to be carried out if the postoperative orders direct the nurse responsible to require a given number of movements at stated intervals and if the surgeon endorses this to the patient and his family. When the patient's coöperation cannot be obtained passive motions are of value as is upward massage of the calves and elevation of the foot of the bed. The importance of leg exercises in postoperative bed patients was discussed at a recent national surgical meeting and Pearse[11] pointed out that ambulation of itself may not prevent thrombosis since even with early ambulation the patient is in bed for the greater part of the twenty-four hours. Personally I believe that for different reasons the patient's best interests are served by getting him out of bed much sooner than has been customary in the past. However, early ambulation is at best but a partial solution of the problem of thrombosis as it is not applicable in the critically sick or for those restricted to bed by a fracture. Therefore in these patients active and passive bed exercises become particularly important.

From the practical standpoint an increased coagulability of the blood develops to a dangerous extent only in a minority of surgical patients. It is to this minority that special attention should be directed in the prophylaxis of embolism. A simple diagnostic test for early signs of this change in the clotting mechanism is highly desired so that these patients can be singled out from the greater number for special effort and care. The customary tests for clotting time and bleeding time do not reveal the change clearly, and although prothrombin time determinations upon diluted plasma are superior in this regard they have the great disadvantage of requiring particularly skilled laboratory technique. de Takats and Fowler[3] have found a possible solution to the problem in their discovery that patients with increased blood coagulability exhibit a striking diminution in their response to a small dose of heparin and that this test can be done fairly simply. A flat heparin tolerance curve, they find, indicates the presence or imminence of thrombosis, and the normal response can be restored in such patients by therapeutic administration of heparin, dicumarol, and so forth.

In the John Sealy Hospital we are now embarking upon a study of the heparin tolerance curve as an index of blood coagulability. Utilization of some such test should be helpful in detecting a tendency toward thrombosis in its earlier stages. Any complaint of pain or tenderness about the calf in such a patient is suspicious of phlebothrombosis. Once it is suspected that thrombosis has occurred efforts should be made to prevent embolism and to minimize propagation of the thrombus. Proximal vein ligation seems to be a rational step in preventing embolism. It is easily applicable when thrombosis is limited to the calf, that is, when the thigh is not swollen and the femoral vein is not tender. Then it suffices to ligate the femoral vein below the profunda, preferably first opening the vein and aspirating any clot present at that level. Such "superficial femoral" ligation does not produce a significant edema. If the thigh is also swollen, the problem is not so simple. Then for effective protection the ligation should be done above the profunda tributary and such ligation of the "common femoral" occasionally results in persistent edema. Homans[6] believed common iliac ligation safer from the standpoint of collateral venous return, but this ligation is a more formidable procedure. In connection with venous ligation an anticoagulant drug such as heparin or dicumarol can be a helpful adjunct in preventing other thromboses, and the difficulties and dangers attending the use of anticoagulants are gradually being overcome.

If the patient exhibits actual acute tenderness along the femoral vein, probably it is better classed as thrombophlebitis rather than phlebothrombosis. It is the experience

that a tender vein is the seat of an adherent thrombus which may be difficult to dislocate even by suction. In such a patient the greatest danger of embolism has passed and venous ligation is scarcely needed. It is more rational to direct treatment toward overcoming infection with chemotherapy while instituting motion so as to minimize the danger of any red clot propagation. In such cases of femoroiliac phlebitis a chronic persistent edema of the extremity is to be feared, and it is in preventing this troublesome sequel that paravertebral sympathetic block may be dramatically effective (Ochsner and DeBakey[10]).

Pulmonary embolism as a result of phlebothrombosis is now recognized as being more frequent than is its classical form in which a massive embolus obstructs the main pulmonary artery and kills in a matter of minutes. It has been reported frequently that half or more of fatally ill patients live an hour or longer. There is a mounting experience to indicate that many such patients can be saved. An attempt to extract the embolus from the pulmonary artery is usually impractical. That it may be unnecessary is founded upon two realizations. Postmortem records indicate that patients may die from a small embolus obstructing a part of one lung (de Takats and Jesser[4]) since small emboli may initiate reflexly widespread and disastrous spasm of the smooth muscle of the coronary vessels, of the pulmonary vessels, and of the bronchi (de Takats, Beck, and Fenn[2]). This harmful spasm may be abolished by prompt therapy with such drugs as atropine and papaverine, whereas undesired effects may follow administration of morphine, digitalis, or adrenalin. Secondly, many emboli are not fatal at the first insult, and the prevention of a second infarct through eliminating the primary source by proximal venous ligation is practicable in many cases. Within one month overseas I saw two deaths from second emboli, and autopsy examination suggested that both deaths could have been prevented if femoral vein aspiration and ligation had been done in the early hours after the first embolism.

The early recognition of the more common but less typical pulmonary embolism is of great importance. Any sudden onset of chest pain accompanied by shock and respiratory difficulty should raise the question. Placing such a patient in a semi-sitting position, administering oxygen, and giving atropine and papaverine intravenously are forms of emergency treatment which may accomplish much in pulmonary embolism and will seldom do harm if it should prove later that the patient is suffering from some other condition. Careful examination may suggest that phlebothrombosis is present in one or both lower extremities. Femoral vein ligation can be life saving in preventing recurrence and it can even be done at the bedside under local anesthesia and with the patient remaining semi-sitting.

There can be little argument that prevention of venous thrombosis is the better method of attacking the problem of pulmonary embolism. In avoiding the venous stasis which seems all important in initiating intravascular coagulation one can afford to give much thought to the earlier ambulation of postoperative patients and to mobility and bed exercises in the period preceding ambulation. Once thrombosis has occurred and is recognized much depends upon the presence or absence of the signs of inflammation. In the absence of inflammatory signs indicating that the thrombus is adherent the patient's safety is enhanced by proximal vein ligation. Although sometimes phlebothrombosis can be diagnosed, at other times its existence will be merely suspected. There is no general agreement as to the indications for femoral vein division. In borderline cases the individual surgeon must exercise his judgment, resting assured, however, that ligation of one or both femoral veins is a relatively innocuous procedure if it is carried out below the profunda junction.

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ABSTRACT OF DISCUSSIONS

Dr. Elbert H. Caldwell, Tyler: Three per cent of all deaths and 6 per cent of all postoperative deaths are caused by pulmonary embolism. There is a confusion of opinion as to how this mortality can be reduced. In one clinic nearly 500 venous ligations were done while in another of comparable size only 2 were done. Some clinics believe anticoagulant therapy with heparin and dicumarol is the panacea, while others rely entirely on exercise and early ambulation. Dr. Moore has done an admirable job of summarizing and systematizing the present status of the question.

Ninety-three per cent of pulmonary emboli oc-

cur in patients over 40 years of age. The percentage is disproportionately high in patients following pelvic and abdominal operations particularly for malignant disease. I believe all such bad risk patients and patients who show signs of phlebothrombosis should be put on anticoagulant therapy. All such patients should have the foot of the bed elevated 10 inches for twenty-four hours after operation, and active exercises should be started early and persisted in. Early ambulation is a great help in many ways.

I believe venous ligation should be reserved for those patients who have had signs indicating one probable pulmonary embolus. It should be emphasized that thrombophlebitis with local and general signs of inflammation does not call for vein ligation.

Dr. J. W. Hendrick, Baltimore, Md.: Dr. Moore has given an excellent discussion of a very important and timely subject. A few additional points will be stressed.

It was formerly thought intravascular clotting developed only in surgical patients, but when a series of cases are carefully analyzed, it is found that it occurs about as frequently in medical as in surgical patients.

The best treatment for this serious condition is prevention. Patients who are likely candidates for this complication are more carefully observed than the routine. However, in the University Hospital the resident and nursing staff are taught to examine carefully the lower extremities of all surgical patients and medically ill older patients twice daily, to palpate the plantar surface of their feet and their calf muscles, and to note the presence of edema, or dilatation of the superficial veins and the presence of pain in sole or calf muscles. The patients are encouraged to flex and extend their feet and move their lower extremities as much as possible. Any postoperative chest pain is carefully investigated to be sure it is not a pulmonary embolism, as a pulmonary embolism is the first symptom often of a silent venous thrombosis. I am sure it is a good policy to do a bilateral ligation of the vein above the thrombus when a phlebothrombosis is found to be present. It is imperative that this be done as an emergency procedure if the patient has had a nonfatal pulmonary embolism. As a rule, ligation of the superficial femoral veins will take care of most cases.

If the services of a good laboratory are at the doctor's command so that daily prothrombin determinations can be made, dicumarol can be tried. However, if the patient has had a pulmonary embolism, it is safer to do a superficial femoral ligation because the uncontrolled use of dicumarol is dangerous.

Daily determinations of the prothrombin time are necessary; superficial femoral ligation and embolectomy are practically without danger, as has been shown in large series of cases.

RED CROSS CHANGES ORGANIZATION

Fundamental changes in the organizational structure of the American Red Cross, the first major changes since 1905, have been adopted by the present governing body, the Red Cross news service has announced. The revisions, recommended by an advisory committee appointed last March to study the organization of the Red Cross in the light of its tremendous growth in membership and services since the 1905 charter was granted, provide at the national level for greatly increased representation from the chapters and from the public at large on the national governing body, and at the chapter level for participation by the membership in all chapter operations.

VASCULAR INJURIES, PARTICULARLY COMPLICATIONS INFLUENCING THE INCIDENCE OF GANGRENE

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The Surgical Service of the 127th General Hospital while in the European Theater of Operations had a number of interesting vascular injuries with severance of large arteries. We wish to give credit to members of the Surgical Service for the cases used in this report, since the series includes cases operated on by six members of the staff. Although the number of cases, 28, is not large, it appears large enough to make a study of the results beneficial.

Most of us in civilian life had had little experience in ligating large arteries following division or occlusion due to injury, experience being limited for the most part to true aneurysms and occlusions the result of emboli. Since medical school days we had been conscious of the sites at which large arteries may be ligated more safely because of collateral anastomoses. Unfortunately it is impossible to choose the site of injury, and it was observed that in war wounds injured vessels even at preferable locations resulted in gangrene to the extremity in a high percentage of cases. Gangrene occurred much more frequently than we had formerly been led to believe. The percentage of gangrene following ligation of large vessels as stated in textbooks of anatomy and in volume 5 of *Military Surgical Manuals*[1] is much lower than our results show. It is our purpose to show why an injured artery may in one case result in gangrene and in a different case with injury at the same site result in a normal extremity. Apparently the complications associated with vascular injuries of war play the major role in the increased incidence of gangrene.

The complications associated with arterial injuries have been extensive damage to soft tissues, fractures, diffuse, hematomata, and edema. Infection, particularly that caused by the gas baccillus, may be a major complication. However, since the incidence of gangrene in our cases has not been influenced by infection the latter is only mentioned.

The wounds were produced by shell fragments, grenade fragments, mine fragments, and bullets, and were penetrating or perforating in type. The only exception was 1

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case in which the injured artery was caused by a simple fracture of the femur.

In some of our cases the artery was completely divided and in others the division was only partial. In 1 case there was a perforating wound of the artery with a lateral wound on each side. In those cases in which the artery was severed by a large rough missile, such as a grenade segment, and there was an associated extensive lacerated wound, the ends of the divided artery were retracted and there was an obstructing clot in each end. Extensive soft tissue damage has a tendency to promote rapid clotting thereby preventing fatal hemorrhage. In such cases, however, the muscular collateral branches may be damaged to such an extent that gangrene results. The same is true when bone is badly comminuted by the missile, the bone fragments injuring surrounding muscle tissue and arterial branches. A bullet usually causes little soft tissue damage, unless the missile strikes bone. A bullet wound through a large artery causes a hematoma since the small wounds of entrance and exit in the soft tissue do not as a rule permit free external hemorrhage. The size of the hematoma will depend on the ease with which blood can penetrate the intermuscular spaces and fascial planes. The hematoma may increase in size until it interferes with circulation of the extremity so much that gangrene results if the pressure is not relieved. The formation of a pulsating hematoma or false aneurysm may be delayed for several weeks following the arterial injury, it being detected after increased activity with rise in blood pressure or slight trauma over the area. Such a hematoma usually pulsates and a murmur is frequently heard on auscultation.

It is stated that a large artery may be completely occluded by actual spasm resulting from trauma to structures about the vessel. Undoubtedly arterial spasm to some degree is present in areas of trauma. Isolation of a large artery such as the femoral with passage of tape about it at times produces definite constriction at the site of the tape. There is probably a contusion of the arterial wall with some thrombosis when the lumen is completely occluded. Such was true in 1 case in which the femoral artery injury was in association with a compound comminuted fracture of the femur produced by a bullet, and is assumed to be true in 2 other similar cases.

The treatment of wounds of large arteries was according to direction of the *Manual of Therapy* of the European Theater of Operations[2]. When the artery was completely severed the proximal and distal stumps were doubly ligated. The companion vein was divided and both stumps ligated in like manner regardless of whether or not there was an associated injury to the vein. The resulting congestion increases the volume of the capillary bed distally. If the artery was only partially divided or was contused with thrombosis, it was cut across and both stumps doubly ligated along with the companion vein as described above. The thrombosed portion of the artery was excised.

It was our policy to expose large arteries proximal to the site of injury by a separate incision before exploring the wound in order to control hemorrhage. Umbilical tape was passed around the artery, but was not tied. With the aid of the tape digital pressure could be applied at any time needed. Pulsating hematomata were approached directly only after the artery had been exposed proximally.

Most of the patients did not reach us less than eight hours following the time of injury. Although they had had plasma and in some instances blood, they showed some degree of shock. Shock was treated with plasma and blood, and as soon as the patient's condition warranted it, operation was done. Shock therapy was continued postoperatively as indicated. The patient was kept warm, but no heat was applied directly to the extremity. Paravertebral sympathetic block was done and was repeated when it was thought there was improvement.

We had little difficulty in deciding whether or not an extremity would live. If when first seen there was absent pulsation, together with coldness and blanching of the skin, gangrene later developed. If the circulation to

TABLE 1.—*Superficial Femoral Artery—Ligation or Occlusion.*

Case	Bone Damage	Soft Tissue Damage	Hematoma	Edema	Line of Demarcation of Gangrene on Skin
J. G.	None	+	+	+	None
*C. O.	None	+	+ + +	+	None
J. P.	None	+	+	+	None
*A. H.	None	+	+	+	None
R. D.	None	+	+	+	None
J. H.	None	+	+	+	None
J. J.	None	+ + + +	+ +	+ + + +	Junction of middle and upper one-third
G. S.	FCC Femur	+ +	+ +	+ +	Middle of leg
S. L.	FCC Femur	+ +	+ +	+ +	Junction of middle and lower one-third
V. S.	FCC Femur	+ + +	+ +	+ +	Junction of middle and upper one-third
L. K.	FCC Femur	+ + +	+ + +	+ + +	Middle of leg
E. C.	FS Femur	+ +	+ + +	+ +	Just below knee

*False aneurysm

the extremity appeared adequate, no gangrene developed following operation. The operation did not change the level of viability to any demonstrable degree. Neither did we see paravertebral sympathetic block prevent gangrene in an extremity with inadequate circulation. We did no primary amputations. It was our policy to delay amputations for several weeks when a definite line of demarcation on the skin was present. This line of demarcation, however, is no indication that the underlying muscles and bone are viable at the same level. The skin is usually viable at a much lower level than the underlying structures. If gangrene of the skin reaches the junction of the middle and upper third of the leg there will be little viability of muscular tissue below the knee.

In table 1 are listed the cases with injury to the superficial femoral artery in which the artery was ligated or occluded. Sudden division of the superficial femoral artery or its ligation for traumatic aneurysm resulted in gangrene only if the profunda femoris area was badly damaged. Such damage of the profunda femoris area was regular with comminuted fractures of the femur but gangrene occurred only once from soft tissue damage in the absence of fracture. This patient, J. J., had an extensive lacerated wound of the anterior and lateral surfaces of the proximal one-half of the thigh with great loss of skin and muscle which was sustained when he threw himself on a grenade which had been placed on the ground as a booby trap. There was complete division of the superficial femoral artery, 1 cm. distal to the origin of the profunda femoris and there were multiple grenade segments as foreign bodies throughout the muscular tissue. The line of demarcation of gangrene on the skin was at the junction of the middle and upper one-third of the leg. However, when amputation was done one month after injury, it was necessary to do a supracondylar amputation because the underlying muscles and bones were not viable below the knee. It was always necessary to amputate the extremity at a higher level than the line of demarcation of gangrene on the skin indicated.

TABLE 2.—*Popliteal Artery—Ligation or Occlusion.*

Case	Bone Damage	Soft Tissue Damage	Hematoma	Edema	Line of Demarcation of Gangrene on Skin
W. B.	None	+ +	+ +	+	Junction of middle and lower one-third
W. R.	None	+	+ + +	+	Junction of middle and lower one-third
L. C.	None	+ +	+ + +	+	Junction of middle and upper one-third
H. D.	None	+ + +	+ +	+ +	Junction of middle and upper one-third
H. K.	FCC Tibia and Fibula	+ + +	+ +	+ + +	Junction of middle and upper one-third
C. W.	None	+ + + +	+ + +	+ +	Junction of middle and upper one-third

Two cases of the superficial femoral artery group had false aneurysms. One was ligated twenty-five days after injury and the other two days following injury.

Table 2 shows the discouraging results with sudden division of the popliteal artery. All of our 6 cases resulted in gangrene. There was 1 patient with a false aneurysm of the popliteal artery, whose case is listed in table 3, who had no gangrene of the extremity. Because of our experience and the experience of others with popliteal ligation we believed that operation should be delayed a month in hope that better collateral circulation would be established. The patient was sent by air to the United States.

In table 3, patients with injuries of the common femoral, profunda femoris, posterior tibial, axillary, and carotid arteries are listed. There are not enough cases in these groups to make the results valuable.

TABLE 3.—*Arterial Division or Occlusion.*

Case	Artery	Bone Damage	Soft Tissue Damage	Hematoma	Edema	Line of Demarcation of Gangrene on Skin
J. C.	Common femoral	None	+	+	+	Middle of leg
*D. C.	Profunda femoris	None	+	+ + + +	+	None
*L. P.	Popliteal	None	+		+	None
J. R.	Posterior tibial	FCC Tibia and Fibula	+ + +	+	+ + +	None None
*P. R.	Posterior tibial	None	+ +	+	+	Great toe, lateral
*H. H.	Posterior tibial	None	+ + +	+ +	+ + +	and plantar surface
*L. I.	Axillary	None	+ +	+ +	+ +	None
*B. P.	Axillary	None	+ +	+	+	None
R. R.	Axillary	FCC Scapula	+ + +	+	+ +	Finger tips
*P. S.	Carotid	None	+	+	+	Good result

*False aneurysm

The only case of common femoral artery division resulted in gangrene. The 5 cases reported by Rose, Hess and Welch[3] also resulted in gangrene. They observed, however, that the line of demarcation of gangrene was at a much lower level in common femoral artery division than in superficial femoral artery division.

The profunda femoris artery was ligated in 1 case because of a large pulsating hema-

toma secondary to a gun shot wound received sixty-five days previously.

The posterior tibial artery was ligated in 2 cases with good results. In 1, the division of the artery was associated with a compound comminuted fracture of the tibia and the fibula, and in the second case the ligation was done because of a false aneurysm. The third patient with posterior tibial artery injury had a false aneurysm apparently above the peroneal. He had had marked soft tissue damage and there was marked edema with infection. There was dry gangrene on the lateral and plantar surfaces of the great toe. This patient was seen by us nineteen days following injury. After chemotherapy and blood transfusions he was evacuated to the United States without ligation of the artery.

Two cases of ligation of the axillary artery between the circumflex humeral and the profunda brachii branches did not result in gangrene. There was a false aneurysm in each case. One artery was ligated ten days after injury, and the other sixty-six days following injury. One patient evacuated to us after division and ligation of the first part of the axillary resulted in gangrene of the finger tips but the wound had been packed and the axillary incision made in such a way as to impair collateral circulation.

There was one arterio-venous aneurysm involving the carotid artery and jugular vein caused by a grenade fragment which was successfully excised with ligation of the artery and vein.

Table 4 shows the relationship between arterial ligation or occlusion and gangrene with comparison of statistics given in *Military Surgical Manual,* volume 5. It can readily

TABLE 4.—*Relationship between Arterial Ligation or Occlusion and Gangrene.*

From Military Surgical Manual, Vol. 5		127th General Hospital	
Artery Ligated or Occluded	Gangrene Per Cent	Gangrene Per Cent	Number of Cases
Common Femoral	21	100	1
Superficial Femoral	10	50	12
With fracture		100	5
Without fracture		14.28	7
Popliteal	0	100	6
Profunda Femoral		0	1
Posterior Tibial			
With fracture, both bones	50	0	1
Without fracture	3	50 (great toe)	2
Axillary			
Below circumflex humeral	9	0	2
First portion	0	100 (finger tips)	1

be seen that when major arteries are injured in association with wounds of modern warfare, the prognosis for survival of extremities is not a good one. The increased incidence of gangrene in war wounds is caused by marked soft tissue damage either alone or in association with fractures. Such damage greatly impairs collateral circulation with gangrene resulting.

SUMMARY

Twenty-eight cases of injuries to major arteries are presented. Twelve cases of sudden interruption of the superficial femoral artery or its ligation for traumatic aneurysm resulted in gangrene only if the profunda femoris area was badly damaged. Gangrene occurred in 6 of these cases but in 5 of the 6 cases there was an associated comminuted fracture of the femur. In 7 cases without fracture gangrene occurred only once.

Six cases of sudden popliteal artery division resulted in gangrene.

The only case of common femoral artery division resulted in gangrene.

Two cases of ligation of the axillary artery between the circumflex humeral and profunda brachii branches did not result in gangrene.

Ligation of the posterior tibial artery was tolerated well.

Lumbar sympathetic block may have possibly influenced the level of gangrene in the lower extremity but in no instance did it seem to influence the occurrence of gangrene.

Of the 9 traumatic aneurysms of large vessels 8 were arterial and only 1 was arterio-venous.

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ABSTRACT OF DISCUSSIONS

Dr. Robert S. Sparkman, Dallas: Figures are now available regarding the incidence and types of vascular injuries sustained in World War II, and the nature and frequency of complications which ensued. It is interesting to see how closely the observations and statistics of other writers coincide with those reported by Drs. Thomas and Pittman.

Acute injuries of major arterial pathways occurred in approximately 1 per cent of all casualties. Fifty per cent of all arterial injuries of the lower extremity were complicated by gangrene requiring amputation, as contrasted with 25 per cent for the upper extremity. The highest incidence of gangrene was seen in popliteal injuries, where amputation was performed in 72.5 per cent of cases. Injuries of the common femoral or common iliac were each associated with an amputation rate of 53 per cent. These figures are based on a consideration of acute arterial injuries only and do not include the late manifestations of arterial injuries such as aneurysm.

All available statistics showed clearly that the incidence of amputation in all types of arterial injuries was distinctly higher where there was associated fracture. This difference was more striking in the upper extremity than in the lower, and was least apparent in injuries of the popliteal artery where the incidence of the gangrene was high, regardless of other factors. For example, in injuries of the brachial artery without fracture the incidence of amputation was 11 per cent, as contrasted with 30 per cent in the group with fracture. On the other hand, popliteal injuries without fracture showed an incidence of gangrene of 67 per

cent as contrasted with 75 per cent in the group associated with fracture.

An analysis of more than 3,000 amputations from the European theater showed that only 12 per cent were the result of clostridial myositis or other serious infection, the remaining 88 per cent being necessitated by vascular injury alone (19 per cent) or by extensive trauma (69 per cent), which obviously implies a high degree of vascular injury.

The combined statistics and observations of surgeons reporting from all theaters on experiences with arterial injuries have been reviewed by DeBakey and Simeone, who reached the following conclusions: "The location and type of injury determine above everything else what the surgeon can do. The great majority of the wounds in World War II were produced by shell fragments, were large, were associated with extensive destruction of tissue, and were not favorably located. As a result, the vitality of the limb was gravely impaired before the surgeons ever saw most of the patients, thus jeopardizing the potential benefits of any therapeutic procedures employed. Infection is perhaps the least important of the limitations imposed by the circumstances of modern warfare . . . It is not infection, but the other circumstances just outlined, which now prevent reparative procedures in most battle injuries of the blood vessels."

Other significant factors in the causation of gangrene to which these authors draw attention are the inevitable time lag between injury and operation, and the amount of blood which the patient has lost. Twenty-seven patients with arterial injury, thought to have received blood in adequate amounts, were studied a week after injury and were found to have an average red blood count of 2.7 million and hemoglobin of 60 per cent. It is obvious that reduction of circulating blood volume will be associated with reduction of circulation through the distal portion of the injured extremity.

I wish to call attention to one point of particular interest in the report by Drs. Thomas and Pittman. It is possible to separate their 28 cases into two groups—a group of 9 cases in which aneurysm was present, and a group of 19 cases in which the lesion was an acute arterial injury. Whereas in the latter group the overall incidence of gangrene was 75 per cent, it is noteworthy that in none of the cases of aneurysm was there any instance of gangrene, regardless of the artery involved. Elkin and Schumacher operated upon 595 consecutive cases of aneurysm with only 1 case of gangrene following operation. This experience has been so uniform as to provoke the statement that the best safeguard for the survival of a limb is for an acute arterial wound to develop into an aneurysm. This is not to be construed as a recommendation that arterial injuries be treated conservatively, since this would imply omission of the fundamental procedure of debridement. Moreover, the development of an aneurysm is often a late manifestation in a wound in which arterial injury was not suspected.

Dr. Robert M. Moore, Galveston: We have all realized that the extent of accompanying local injuries has a great bearing upon the incidence of gangrene following the interruption of trunk arteries. Drs. Thomas and Pittman have illustrated this clearly and have shown, moreover, that in the thigh a specific injury, comminuted fracture of the femoral shaft, is particularly important. It is not unusual that a missile which divides the femoral artery below the profunda femoris branch also strikes the shaft of the femur to cause comminution. If the displacement of the bone fragments is at all extensive, the laceration of adjacent tissues including the branchings of the profunda femoris will be so severe as to amount to a division of the profunda artery, at least as regards the transportation of blood toward the tissues distal to the knee. From a practical standpoint such a patient has suffered division of both of the main arterial trunks of the thigh, and the incidence of gangrene will be exceedingly high just as when the popliteal artery is divided. Since, as shown by Drs. Thomas and Pittman, the incidence of gangrene from division of the femoral artery below the profunda is quite low in the absence of fracture, it is my belief that the relationship is so important that the two conditions should be classed as distinct injuries, and that all reports of the incidence of gangrene from femoral artery division should distinguish between cases in which the femur is fractured and those in which it is not.

ANESTHESIA FOR CESAREAN SECTION

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The present day technique for cesarean section is not devised for use when the mother is in a state of "articulo mortis," but as a life saving procedure for both the mother and the child. Anesthesia has played a prominent part in the accomplishment of this fact. Unfortunately, respiratory and circulatory depression of either the mother or the child (or both) is one of the prices that are frequently paid for adequate relief of pain. These hazards are often evolved with the misuse of volatile and nonvolatile drugs.

For practical purposes it may be assumed that prenatal complications including the mother and/or the fetus are present because these complications are usually the indications for surgical intervention. On this basis, it is the obligation of the obstetrician and the anesthesiologist to coöperate in the management of the case so that all obstetric difficulties may receive due consideration.

A review of 120 consecutive cesarean sections conducted during inhalation anesthesia has been made to estimate the morbid effects of pain relief.* Before induction of anesthesia the operating room, equipment, and staff were in readiness. The surgeons were scrubbed and the patient's abdomen was prepared. Sterile drapes were placed as soon as the patient was anesthetized. This routine was established because the duration of administration of the anesthetic drug and the depth of anesthesia maintained determine the amount of tissue saturation, which in turn determines the degree of volatile drug depression of the baby.

Cyclopropane, by the to and fro absorption technique, was used in 114 of the cases. For cesarean section cyclopropane may be con-

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*Cases from the State of Wisconsin General Hospital, Madison.

sidered the optimum drug of the inhalation family for several reasons. It is pleasant, nonirritating, and rapid in action. These factors are important in the management of the apprehensive patient who is permitted no preoperative sedation other than atropine or scopolamine. As the induction is rapid, there is a minimum of excitement, retching, and mucus secretion. This is essential because the excited patient requires a much heavier dose of the anesthetic drug, and excess mucus interferes with adequate respiratory exchange. A minimum of anesthesia, an adequate airway, and good respiratory exchange provide a satisfactory surgical field. For low cervical section only, is it necessary to worry about relaxation of the abdominal muscles. As resection of old scars and adhesions require time, most obstetricians are willing to omit this procedure until after delivery of the infant, unless it is necessary in order to obtain an adequate exposure.

When the obstetrician begins to open the body of the uterus, the anesthetic gases are immediately expelled from the breathing system to guard against excess tissue saturation. One hundred per cent oxygen is substituted and the mother's respiration is controlled by gentle pressure on the breathing bag until the baby is delivered and the cord clamped. Positive pressure control of respiration is necessary because with the reduction of the concentration of the anesthetic agent the plane of anesthesia approaches the reactionary stage; and if the patient is permitted to hold her breath, vomiting may follow immediately. As soon as the cord is clamped, the administration of the anesthetic drug is resumed and surgical anesthesia maintained for the completion of the operation.

TABLE 1.—*Indication for Cesarean Section.*

Dystocia	91
Funnel Contracted Pelvis	
Cephalopelvic Disproportion	
Previous Section	
Sterilization	2
Toxemia	9
Cardiac or Cardiovascular-renal Disease	5
Hemorrhage	10
Placenta Previa	
Premature Separation	
Ruptured Uterus	
Welfare of Baby	3
Elderly Primipara	
Uterine Inertia	

Oxygen can be supplied to the mother and fetus in as high concentrations as desired. This is essential not only to the viability of the fetus but is often mandatory in cases of toxemia, anemia, cardiac disease, or where there is unusual blood loss.

Contrary to general opinion, cyclopropane, if expertly used, can be safely administered to the patient with borderline cardiac decompensation or auricular fibrillation. Many of these patients seem to improve when anesthetized with cyclopropane if the induction is without stress or strain. This condition is possibly due to the availability of an excess of oxygen. On the other hand careless administration of cyclopropane may be rapidly fatal to even the most healthy person.

DISCUSSION

In the present series, cesarean section was the elected technique in approximately 5.5 per cent of the obstetrical admissions. There were 99 classical, 10 low cervical, and 11 radical sections. The indications for these sections are listed in table 1.

TABLE 2.—*Maternal Postoperative Complications*

Death	1
Arrhythmia or Tachycardia	3
Marked Blood Pressure Fall	1
Bronchopneumonia	1
Cystitis or Retention	4
Nausea and Emesis	11
Distention	7
Ileus	1

Among the postoperative maternal complications (table 2) there was 1 maternal death. This occurred four hours after the operation. The patient had a cretin pelvis and presented an extreme toxemia of pregnancy. The baby weighed four pounds two ounces and after five minutes of resuscitative measures, lived and regained its birth weight within one week. Three instances of arrhythmia or tachycardia and 1 of severe blood pressure fall occurred after section in which there was severe hemorrhage. Bronchopneumonia was present in 1 patient three days after a section was done because of a ruptured uterus. In this case there was a question of debility and an inadequate pulmonary ventilation.

Among the neonatal complications listed in table 3, there were 3 deaths. Two infants were of mothers having severe toxemia and 1 was a six weeks premature infant that showed syphilitic involvement. Eleven infants required artificial respiration with oxygen and tracheobronchial toilet to assure viability. One was of premature birth and 3 of toxic mothers. The remaining 8 appeared to have either serious respiratory or circulatory depression, although fetal distress was not evident during the prenatal or parturition

TABLE 3.—*Neonatal Complications.*

Death	3
Artificial Respiration Necessary	11
Delayed Cry	
Respiratory Obstruction	9
Sleepy	14

period. One exception was a child whose mother had received 5 grains of barbital and .01 grain of scopolamine before delivery. The anesthetic drug cannot be considered free from blame in these 8 cases or in the 14 sleepy babies who responded satisfactorily without artificial respiration.

For preoperative sedation scopolamine was used in 91 instances and atropine in 21. There seemed to be no depression directly attributable to the scopolamine except in the case where it was combined with barbital.

The postoperative maternal and neonatal morbidity in this series leaves much to be desired-even though it compares favorably with reports by authors using different drugs and techniques.[1, 2, 3, 4, 5, 6, 7]

Many obstetricians, lacking the services of a trained anesthesiologist, must of necessity use spinal anesthesia and, therefore, become adept in its use. Those who obtain the lowest mortality and morbidity rates do so by using small amounts of a relatively nontoxic drug such as procaine. The patients are observed carefully during the procedure for respiratory and circulatory depression. Oxygen for respiratory depression, intravenous fluids and oxygen for circulatory depression and vasopressor drugs for severe blood pressure falls tend to save the mother from serious complications. The mother who barely survives the complications of spinal anesthesia is not necessarily a good recommendation for its use.

Torrie,[7] who reported a series of 120 sections under spinal anesthesia with satisfactory results, pointed out three hazards that may lead to serious difficulties: (1) The level of anesthesia ascends higher than expected and is more difficult to control if the patient is having hard uterine contractions. (2) The blood pressure level is more likely to drop. A serious drop may impose the deleterious effects of hypoxia on both mother and fetus. (3) The respiration of the patient is more easily depressed if the anesthesia ascends above the level of the xiphoid.

SUMMARY

The favorable results in this cyclopropane series may be attributed to four essential factors: (1) The coöperation of the obstetrician and anesthesiologist in preparing the patient before the administration of the anesthetic begins. (2) The control of the anesthetic drugs which are rapidly effective and immediately reversible, adequate oxygenation, and effective elimination of carbon dioxide. (3) Prompt delivery of the infant soon after the mother is anesthetized. (4) The presence of trained persons who are competent to care for the infant during the first few minutes after delivery.

CONCLUSION

Cyclopropane anesthesia, expertly administered, has the advantage of minute to minute control which tends to limit postoperative depression of respiration and circulation. This may commend its use for cesarean section.

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ABSTRACT OF DISCUSSION

Dr. Nicholson J. Eastman, Baltimore: I have listened with much interest to Dr. Allen as he talked and I mulled over in my mind our experiences with various anesthetic agents. It seems to me we have no complete 100 per cent agent that is applicable for all patients; we must pick and choose. Dr. Allen implied a trained physician anesthetist is necessary for the administration of cyclopropane. The border line is small for safety. He cited the objection of the behavior of cardiac cases. I would like to cite our experience: one patient after another experienced arrhythmia. We were afraid before of cyclopropane in heart cases for that reason. In trained physicians' hands it may be quite satisfactory. Those who use it claim excellent results. High blood pressure cases are extremely vulnerable to falls; with low blood pressure, the objection is obvious. I have seen few cases of dead babies with spinal anesthesia. I have seen the blood pressure fall extremely low and, in spite of the administration of ephedrine, stay low. There is another anesthetic agent that is scarcely ever mentioned in textbooks which I would like to cite at least for consideration because we have had such gratifying experience with it. It is intravenous sodium pentothal. Most obstetricians are afraid of it because they think it has a deleterious effect on the baby. We have found that pentothal is being used more and more and have to date delivered 3,000 patients with it and low forceps. We have done 250 cesarean sections with it. It has definite advantages in that the patient wakes very promptly with no signs of nausea and has a very pleasant period following regaining of consciousness. Following cesarean section it stands between ether and spinal anesthesia since it gives more relaxation than spinal and less than ether. The results for the baby are excellent and I have used it for years in my private practice. With cesarean section we do find that it is desirable to get the patient draped and prepared before starting the pentothal so that the duration is as short as possible for the delivery of the baby.

Any one who reviews the literature finds that every year a substantial number of mothers die and even sometimes as the direct result of anesthesia. It is one of the problems that faces us. Some patients do not take anesthesia well and we are indebted to the essayist for bringing before us this important paper.

Dr. Allen, closing: I wish to thank Dr. Eastman for his very well put points and I certainly agree

with him that there is no 100 per cent agent for cesarean section. After all, it is more important that the agent be the one best known to the administrator and the technique the one he knows best.

In regard to the cardiac arrhythmia that may occur under cyclopropane anesthesia: I think I will stay out of this discussion at the present time. However, we do not feel it is a contraindication and we are gradually accumulating real evidence for our belief. Adrenalin should not be injected intravenously during cyclopropane anesthesia. In the hypertensive the fall in pressure in spinal anesthesia may be very marked. If there is watchful waiting at the head of the table and an open airway all the time, sodium pentothal may be quite satisfactory.

INTRACRANIAL AIR STUDIES IN INFANTS AND CHILDREN

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The value of pneumo-encephalography and ventriculography in the differential diagnosis and localization of intracranial lesions is generally recognized today, as are their limitations and dangers. Apparently the pendulum of opinion has receded from the extreme of injudicious over-use of these procedures which, through the inevitable mishaps that followed, led in turn to avoidance of their use even when indicated. There was a period, indeed, during which some institutions were required to perform these examinations as part of their routine workup for obvious mental defectives!

In the pediatric age group, intracranial pneumograms may often help fill the gaps in the clinical picture which occur in case histories that are incomplete subjectively and even objectively. Parents' information is not always satisfying with respect to the normal development of their children and the significant deviations therefrom. Information from the children themselves is usually incomplete or unreliable. It is not to be inferred, however, that the complete neurological examination cannot diagnose and localize intracranial lesions in most cases, but rather that the pneumogram offers a degree of reliability, safety, simplicity, and accuracy not yet approached by electro-encephalography or arteriography in children.

The usual precautions involved in the procedure are even more worthy of emphasis for children than for adults, due in part to the preponderance of subtentorial over supratentorial tumors in the ages up to 16 years. Before encephalography is attempted, intracranial pressure should be determined as normal, or at worst only slightly elevated; in cases of doubt as to pressure or type and location of a suspected intracranial lesion, the safety valve of a T-needle in a lateral ventricle might be used. Ventriculograms, too, are not without danger, but are probably preferable in most instances. However, they do not help in the study of the subarachnoid pathways or the basal cisterns, and these often hold the key to the diagnosis.

One satisfying result of the pneumogram has been the reduction in the number of simple decompressions performed, as opposed to more specific operations or radiotherapy. Brain injuries caused by herniation through decompression openings have been noted, indicating that the procedure is not without danger.[6]

A review of histologically proven intracranial lesions for the past five years at John Sealy Hospital discloses no significant de-

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Read before the Section on Radiology and Physiotherapy, State Medical Association of Texas, Annual Session, Galveston, May 8, 1946.

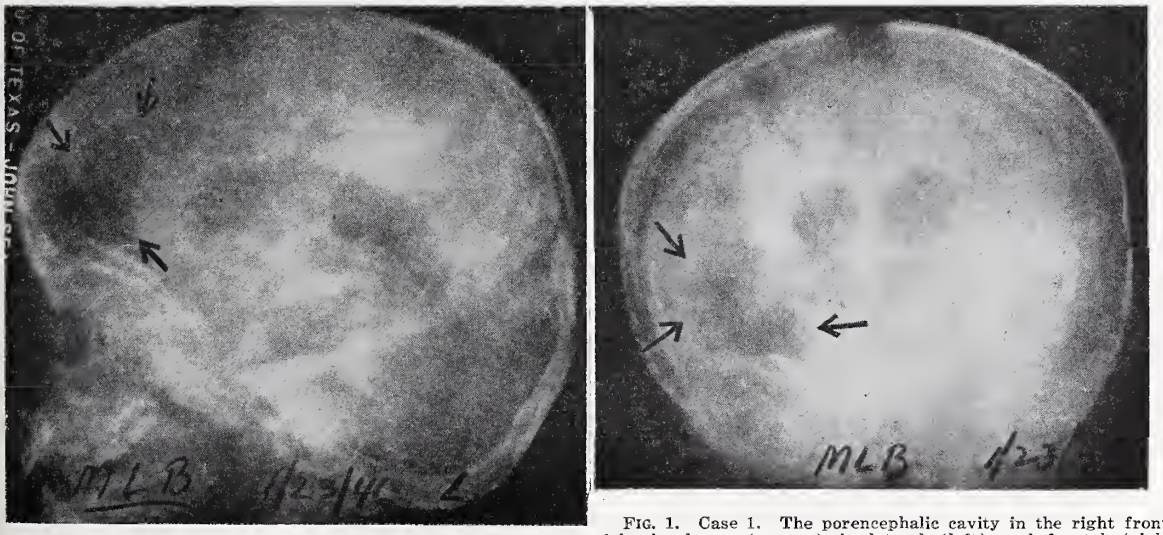


FIG. 1. Case 1. The porencephalic cavity in the right frontal lobe is shown (arrows) in lateral (left) and frontal (right) views. The sagittal and coronal sutures are separated.

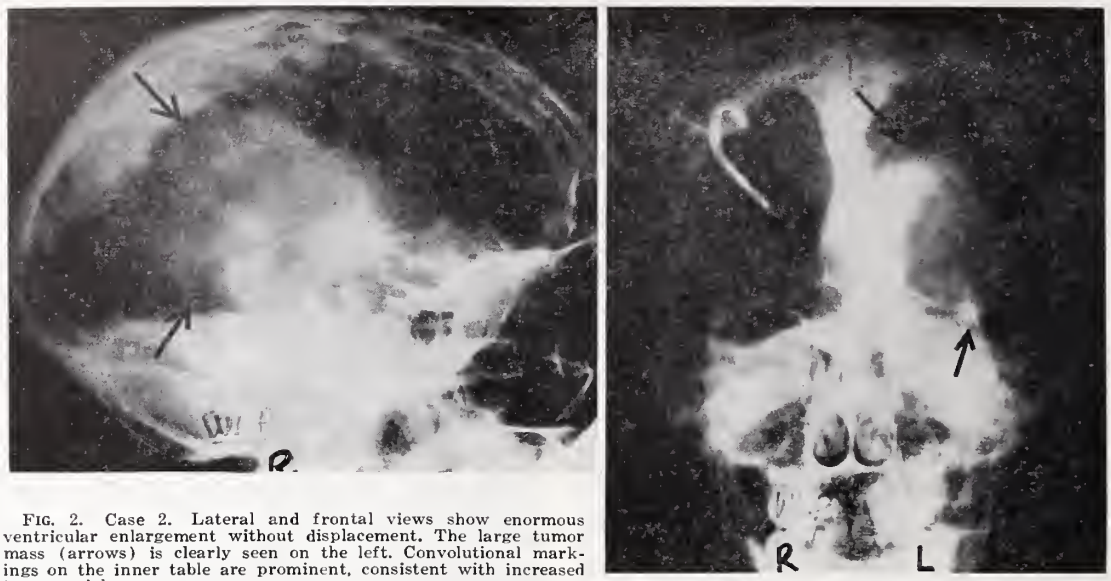


FIG. 2. Case 2. Lateral and frontal views show enormous ventricular enlargement without displacement. The large tumor mass (arrows) is clearly seen on the left. Convolutional markings on the inner table are prominent, consistent with increased intracranial pressure.

viations from the types and percentages of lesions in other general hospitals with a neurosurgical service.[1, 3] Among the tumors, the subtentorial ones have been most frequent, and there have been such other lesions as congenital internal hydrocephalus, abscess, subdural hematoma, localized and generalized cortical atrophy, porencephaly, and a scattering of the rarer entities. One exception to the expected incidence of neoplasm has been the absence of craniopharyngioma during this period.

The material of this presentation is intended to demonstrate the diagnostic significance of pneumograms for cases in which the clinical diagnosis was confirmed or modified. It is not an expression of statistical incidence of intracranial lesions found here.

CASE REPORTS

CASE 1.—A white, 20 months old girl was brought to the hospital by a social worker. There was no adequate history ever obtained, except for a questionable one of trauma to the head. The duration of the observed conditions was described as "recent."

Physical Examinations.—This baby was well developed and well nourished, but held her limbs in spastic extension, her head and eyes to the left, showed no sign of recognition of her environment, and had increased deep reflexes bilaterally. Her head was enlarged, with a positive MacEwen sign.

Roentgen Studies.—Skull roentgenograms displayed suture separation and enlargement of the calvarium, indicating increased intracranial pressure. An encephalogram (Fig. 1) revealed a moder-

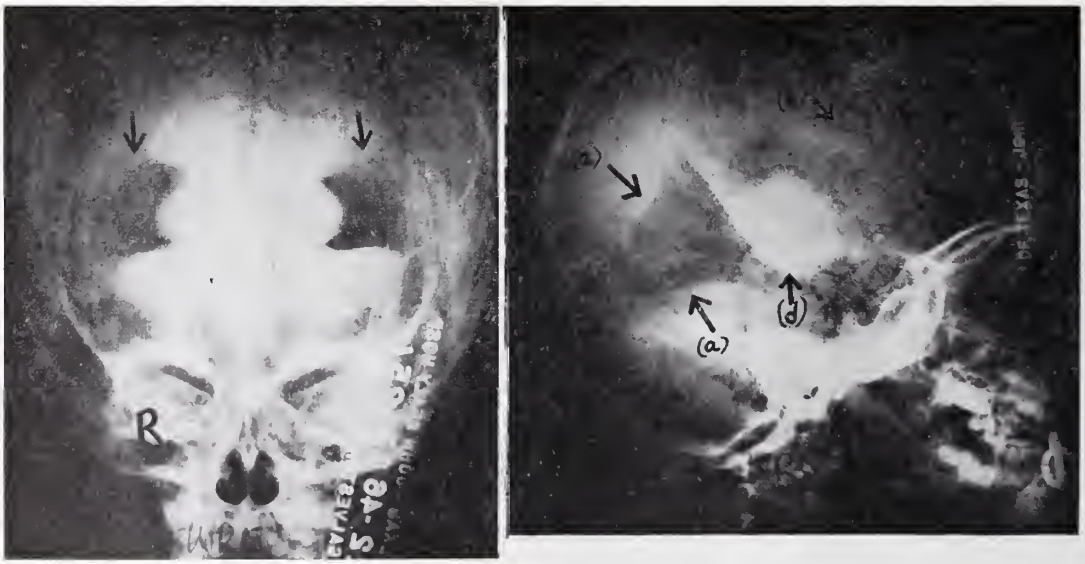
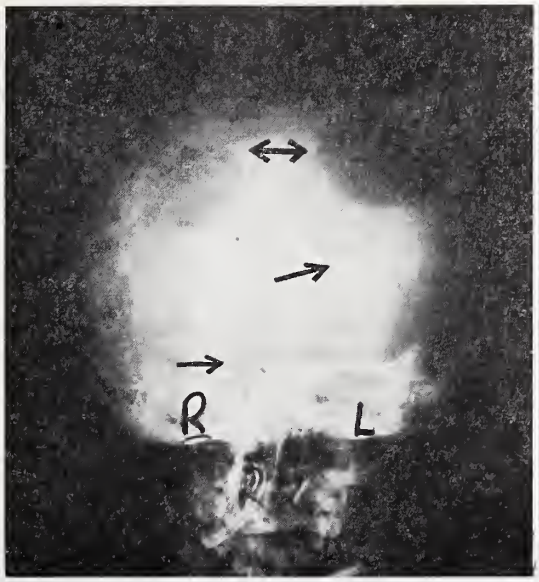


FIG. 3. Case 3. (Left) The lateral ventricles are dilated and separated (arrows). Their mesial margins are concave. The third ventricle is not elevated.

(Right) The posterior horn of the lateral ventricle is dilated (a). The entire callosal sulcus (b) and the cingulate sulcus (c) are seen. A soft tissue mass (d) apparently represents a cyst of the septum pellucidum.



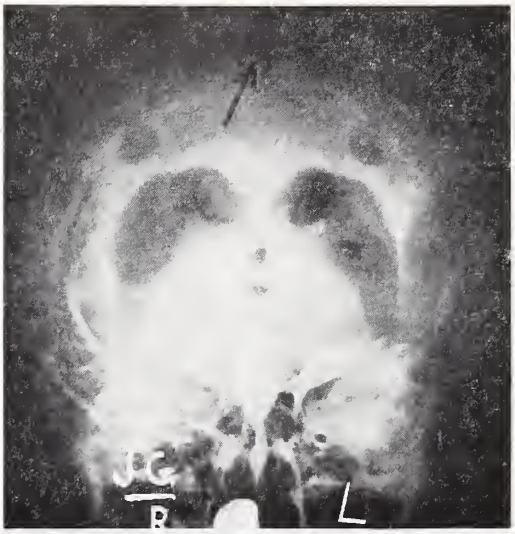


FIG. 4. (Left) Case 4. Upper arrow shows dilated lateral ventricles, the left one elevated. Middle arrow shows elevation of left leaf of tentorium. Lower arrow shows fourth ventricle displaced to the right.

(Right) Case 5. The sagittal suture is wide (arrow), and the lateral, third, and fourth ventricles are dilated, with deformity of the fourth.

ate generalized ventricular dilatation, absence of cerebrocortical pathways, and an irregular porencephalic cavity in the right frontal lobe; there was no displacement of the midline structures.

Course.—With the diagnosis of porencephaly, the infant was discharged without treatment.

Discussion.—This case presents the recurrent problem of etiology in porencephaly. Good evidence exists to indicate that it may be congenital or acquired by trauma or meningo-encephalitis.[4, 6] The immediate mechanism in either case is apparently interference with the vascular supply to a portion of the brain. In this instance, the inadequate history hinders the interpretation, but I would favor a traumatic etiology in view of the possible head injury, the irregular appearance of the area of porencephaly, and the absence of demonstrable subarachnoid pathways.

CASE 2.—A white girl, 13 years old, entered the hospital with a history of frontal headache for the past eighteen months, followed by ataxia, weak legs, nausea, vomiting, and irregular fever. The initial diagnosis at home had been "poliomyelitis."

Physical Examination.—The child was semicomatose throughout her remaining six weeks of life. The salient neurological findings were nuchal rigid-

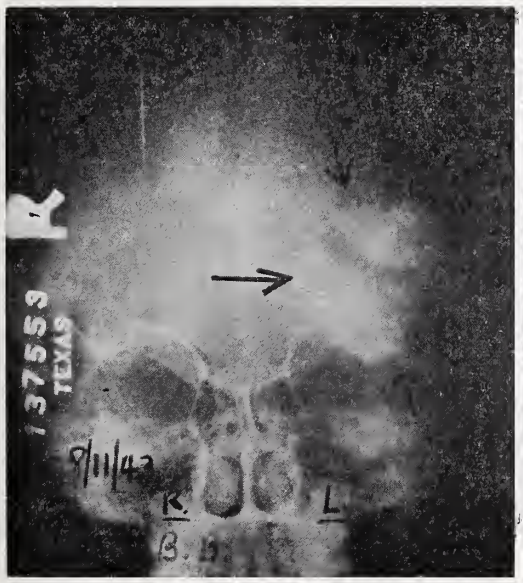


FIG. 5. Case 6. The calcium-bearing mass preoperatively occupies a large volume of the left parietal region.

ity, inability to walk, positive Romberg sign, and positive Babinski sign bilaterally.

Roentgen Studies.—Skull roentgenograms disclosed evidence of increased intracranial pressure with greatly exaggerated convolutional impressions on the inner table. The ventriculogram (Fig. 2) disclosed enormous dilatation of the lateral ventricles and a large soft-tissue mass projecting into the left lateral ventricle from the region of the midline and third ventricle. The impression was that of an obstructing tumor in the third ventricle or a possible pinealoma.

Necropsy.—A massive tumor, histologically a glioblastoma, was found originating in the left thalamic area. There was recent intraventricular and subdural hemorrhage.

Comment.—The thalamus, considered by many neuroanatomists one of the basal ganglia, usually produces tumors characterized by varying syndromes of muscular dystonias. It forms the dorsolateral part of the wall of the third ventricle. The roentgenographic appearance of this tumor is in keeping with the location of the thalamus. The clinical neuromuscular changes are consistent with this neoplasm, but the vomiting was probably caused by pressure effects on the fourth ventricle affecting the vagus center. Similarly, involvement of the thermoregulatory center in the basal ganglia may have accounted for the fever.

FIG. 6 Case 6. Two and a half years later, and two years after operation, the mass is smaller than originally (although some growth has occurred since partial removal). The upper broad arrow in the frontal view (left) points to separation of the operative bone flap; an increase in intracranial pressure is indicated.

CASE 3.—A 3.5 year old white boy was presented at the Diagnostic Clinic. Up to 3 months of age his development was apparently normal. At that age, he had an upper respiratory infection with a questionable encephalitis allegedly manifested by a unilateral strabismus of one year's duration.

Physical Examination.—The left arm was used more than the right, which displayed involuntary movements. The gait was clumsy and wide-based. Plantar response to stroking was normal. The electroencephalogram had an irregular convulsive pattern without localization characteristics.

Roentgen Studies.—The pneumoencephalogram (Fig. 3) showed dilated lateral ventricles, particularly in the posterior thirds of their bodies and occipital horns; wide separation of the lateral ventricles with concave mesial margins; equal displacement of each lateral ventricle from the midline and an apparent round soft tissue mass between them.

Comment.—This was a case that occasioned considerable discussion, and was held by some observers to be an example of agenesis of the corpus callosum. This is a rare entity, described first by Davidoff and Dyke in 1934,[2] with rather striking roentgenographic appearance. Superficially there is some resemblance between this case and agenesis of the corpus callosum, but there are significant differences which, in my opinion, exclude such a diagnosis. As the illustrations show, the lateral ventricles do not have a dorsal peaking but rather a blunt dorsal margin; the callosal sulci are visible and the cingulate gyrus and sulcus above the left one; the third ventricle is normal or displaced downward slightly; and elongation of the mesial sulci, radiating from the roof of the third ventricle, is not present. The radiologic diagnosis is cyst of the septum pellucidum. It may be that the cyst is secondary to the encephalitis alleged to have existed after the age of 3 months. A report on serum sent elsewhere for encephalitis virus antigen study has not been made up to this time.

CASE 4.—A 15 month old white baby with a history of normal development to the age of 12 months had a sudden tonic convulsion preceded by a cry, and characterized by rotation of the head to the right, increasingly severe weakness and incoordination over a period of six weeks.

Roentgen Studies.— Although skull roentgenograms showed evidence of increased intracranial

pressure, the parents took him home against medical advice. Several weeks later they returned the baby to the hospital and stated that in the interval projectile-type vomiting had developed, followed by weakness of the left side, cross temper, and restlessness.

The ventriculogram (Fig. 4) in this case confirmed the clinical diagnosis of left cerebellar tumor. The illustrations show the left infratentorial space-occupying lesion with secondary dilatation of the ventricles, displacement of the fourth ventricle to the right and of the left leaf of the tentorium cerebelli dorsally. The operative and histological diagnosis was astrocytoma of the left cerebellar hemisphere.

CASE 5.—A white boy. 10 years old, was presented with a story of irregular vomiting increasing in frequency over a period of six months. There was no headache and no disturbances of vision, speech, or gait. He had been treated vigorously, by the family physician, for pylorospasm.

Here, a presumptive clinical diagnosis of tumor of the fourth ventricle was confirmed by ventriculogram and operation, which disclosed a medulloblastoma of the fourth ventricle, extending over the medulla and cervical cord.

Roentgen Studies.—The ventriculogram (Fig. 5) showed dilatation of all the ventricles, some deformity of the fourth, and moderate separation of the sagittal suture, as illustrated.

Comment.—Cases 4 and 5 are examples of the more usual conditions in children, usually in conformity with the clinical observations, as these were.

CASE 6.—This 10 year old white boy has been observed since January, 1941. At that time he had a history of right-sided epileptiform seizures for four years, with no jerking of the limbs or biting, but with his head turned to the right occasionally. No history was elicited to indicate a significant event preceding the onset.

A clinical diagnosis of epilepsy was made, and the etiology suggested was tuberculoma, apparently influenced by the roentgen demonstration of a calcified left parietal mass. A perforator biopsy yielded tissue diagnosed as astroblastoma with considerable gliosis and a negative acid-fast stain. A chest roentgenogram appeared normal.

The course became progressively worse, with increased severity of seizures, frequent falls, and headaches. Roentgen studies displayed increasing size of the lesion, as illustrated in 1943 (Fig. 6). In 1944, operation was performed and 100 Gm. of tumor tissue was removed. Histologically it was very vascular, with small tubular calcifications. The pathologic diagnosis was vascular glioma.

Although there has been slow symptomatic improvement, the tumor is again growing and, as indicated in the illustrations, there is evidence of increased intracranial pressure now (Fig. 7).

Comment.—Although pneumography was not performed, this case is presented because of its location, its roentgen appearance, and its misinterpretation originally as tuberculoma. Tuberculoma is not only relatively infrequent now, but calcification in it is rare, occurring in only 11 of 815 tuberculomas collected by Scott and Graves[5] in 1933 from the literature, for a percentage of 0.01. In location this neoplasm is among the minority of children's tumors, and histologically it is most peculiar, suggesting a slowly growing glioma with considerable glial proliferation and vascular calcification.

SUMMARY

Intracranial pneumography is a relatively safe and accurate means of diagnosing and localizing intracranial lesions, assuming that the procedure is in competent hands with due precaution against the recognized dangers. In children it may be of particular value in view of the often unsatisfactory histories and even examinations, and makes the localization definite more often than not.

Illustrative cases are presented.

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ABSTRACT OF DISCUSSION

Dr. S. N. Snodgass, Galveston: We are dependent upon roentgen studies in the diagnosis of many of the brain lesions encountered in children. For example, we recently had a comatosed child in the hospital for a period of two or three weeks in which the diagnosis of medulloblastoma was not made until roentgen studies had been accomplished. Ventriculography is often desirable when neoplasm or subdural hematoma is suspected. In encephalography I believe that one should remove sufficient fluid to enable adequate visualization of the cephalic structures. The use of the horizontal x-ray beam in visualizing structures and fluid levels is of definite value. The routine use of flat roentgenograms is sometimes forgotten in these cases. I have seen a number of children who have gone along for years without a definite diagnosis in which such a procedure later revealed the presence of neoplasm.

ARTHRITIS CAMPAIGN OPENS

The National Arthritis Research Foundation on October 7 formally opened its campaign to raise $2,500,000 to attack the problem of the causes, cure, and prevention of arthritis and those rheumatic diseases directly related to it. The Foundation recently announced the names of nineteen prominent leaders as members of its National Medical and Scientific Advisory Council to direct all research and medical activities of the Foundation. The council members represent eleven specialties: arthritis, bacteriology, general medicine, heart, metabolism, nutrition, orthopedics, pathology, physical medicine, physiology, and virology.

The recently organized Foundation expects to build a research center at Hot Springs National Park, Arkansas, national headquarters of the Foundation, to house the principal laboratories and headquarters staff. In addition, grants-in-aid are to be made to various universities and research centers to carry out correlated investigations.

All who are concerned with mass x-rays of the chest should be on the alert for possible cancer of the lung.—Editorial, Ohio State M. J., April, 1946.

HERPES ZOSTER

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Herpes zoster is a severe debilitating disease. An enormous amount of work has been done in recent years in the investigation of the pathology, treatment, and various manifestations of herpes zoster. It has been known to occur in the proportion of 1 to 2 per cent of all diseases of the skin. It is usually not dangerous except when there is involvement of the eye. The disease may be of long duration, the period ranging from weeks to many months. It occurs with the greatest frequency and with most severity in the latter half of life.

The most complete review of the literature of herpes zoster is given by Edgerton.[5] He believes there is a true epidemic and a symptomatic zoster. The true zoster may run a definite course and is not related to other diseases. The true zoster is contagious and bears a resemblance to varicella, encephalitis, and anterior poliomyelitis. An attack usually conveys an immunity and like other exanthemas, recurrence is unusual. It presents many symptoms commonly observed with eruptive febrile diseases, such as malaise, digestive disturbances, and fever which usually subsides with the appearance of the eruption. In the symptomatic zoster there is usually a very different history from that of the epidemic form. The eruption is not caused by a virus in this latter group but by secondary involvement of the nerve or posterior root ganglion in the course of some other disease.

Baird[1] also considered that the accumulated evidence supports the opinion that true herpes zoster is essentially an acute posterior poliomyelitis caused by a filtrable virus. It is a transmissible disease and totally unrelated to the virus of herpes simplex.

We shall not consider the differential diagnosis but will limit our discussion to the symptomatic form of the disease.

PATHOLOGIC PHYSIOLOGY

The pathologic physiology of herpes zoster involves a consideration of all agents that may produce any type of injury to the dorsal root ganglion. These include pressure of tumors, traumatic injuries, exudates of systemic disease, poisoning by heavy metals such as arsenic, blood dyscrasias, Hodgkin's disease, and vertebral disease. The mechanism of the distinctive skin lesions of herpes zoster is of considerable importance. It seems that the various injurious influences act on the posterior root ganglion, producing vasodilatation of the corresponding segment of skin and muscle. There are numerous theories of explanation of the action of the process in producing the vesicles.[1, 7, 9, 12] The essential vesicular unit is a cluster of vesicles situated on a basic plaque of erythema. Several such clusters are usually present and may involve any part of the body. The vesicles themselves are ordinarily tense and thick walled.

The pain of herpes zoster is explained on the basis of inflammation or degeneration of sensory nerve fibers entering the dorsal root ganglion. This pain is variable in intensity. It may precede or accompany the skin manifestations, and especially in older people it may occur as a severe neuralgia and may persist for months or years after the disappearance of skin lesions.

Symptomatic herpes zoster is usually frequent in persons who are overworked or ill. The appearance of the eruption is usually preceded by malaise, neuralgia, and hyperesthesia of the affected area. The acute phase usually runs from ten to thirty days. Second attacks are very rare.

DIAGNOSIS

The diagnosis is usually easily made but in cases where the vesicles are confined to some obscure locality such as the eye, ear canal, mouth, or bladder, the diagnosis is more difficult. A lumbar puncture may disclose the characteristic zoster lymphocytosis of the spinal fluid. In the early stage of zoster or during the first or second day, one may encounter cases where there is erythema but no pain or vesicles. The unilateral distribution of the erythema may be helpful. Numerous cases have been reported in association with leukemia.

Occasionally the process is bilateral[4] as in the trigeminal ganglia and frequently there is a generalized form.[14] Most of the reported cases with multiple lesions have occurred in association with severe constitutional illness, such as Hodgkin's disease or leukemia.

TREATMENT

Many methods of treatment have been advocated. There are supportive measures such as protection of the lesions themselves and application of calamine or soothing lotions. The use of flexible collodion applied to the lesions is protective. Subcutaneous injections of thiamine chloride and the use of cobra venom have been employed with fair results.[2, 11] Local injections of procaine for

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nerve block[6] probably give the quickest relief and relief is often permanent.

Roentgen therapy is not new. Vignol[13] was probably one of the first to advocate its use. Keichline[8] in 1934, reported 62 cases treated by irradiation. Of this group, 90 per cent were completely relieved by one treatment. He used 150 r, filtered through 3 mm. aluminum at a distance of 30 cm. Tuggle[10] in 1940, reported 72 cases treated with irradiation. Of those treated within seven days of onset of symptoms, 89 per cent were cured. This is a striking comparison with 54 per cent of cures in the series whose symptoms were more than thirty days old. Tuggle's method was 200 r, every other day, for five or six treatments, using 200 kilovolts through 1 mm. copper filter at a 50 cm. distance.

The skin lesions of our treated cases showed the nerve root involvement in essentially the same distribution as in the series of Keichline's patients: cranial 6, cervical 10, thoracic 35, and lower spine 7.

The result of treatment tabulated according to duration of symptoms followed very closely Tuggle's series of cases. In our series of 57 cases there were 24 (41 per cent) males and 33 (57 per cent) females. The majority of the patients, 35 (63 per cent), were more than 50 years of age.

TABLE 1.—*Distribution According to Age and Sex.*

	Total	10-20 years	21-30 years	31-40 years	41-50 years	51-60 years	61+ years
Males	24	1	0	2	8	6	22
Females	33	2	2	4	3	7	0
	57	3	2	6	11	13	22

Our method follows very closely that of Tuggle. A total of 800 to 1,000 produced better results. We used 200 r daily, the factors being 200 kilovolts, 0.5 mm. copper and 1 mm. aluminum filter at 50 cm. distance. The patients showing immediate increase in pain following the first treatment responded more readily to the therapy.

TABLE 2.—*Results According to Duration of Symptoms before First Treatment.*

		1-7 days	8-14 days	15-28 days	29+ days
200 to 600 r.	16 cured	6	4	1	5
	7 improved	—	—	2	5
	7 failed	—	1	1	5
800 to 1,000 r	22 cured	10	6	4	2
	3 improved	—	2	1	—
	1 failed	—	—	—	1
	Total	16	13	9	18

Of the total cases treated, 38 were cured, 10 were improved, and 8 were failures.

Of the 16 patients with symptoms less than one week old, all except 1 were free of pain in seven to ten days. Of the 18 patients with symptoms of more than 29 days, 11 (60 per cent) were either only improved or a failure. Ten of these patients, however, had less than 600 r, and we believe this in part explains these figures. The percentage of cures in the early cases seems to parallel closely the results of other writers.

SUMMARY

Roentgen therapy is an effective method of treatment in herpes zoster. It is true that procaine injection does produce quicker results but often there is a latent post herpetic neuralgia. The combination of procaine injection and irradiation sounds feasible. The quicker the patient is treated after the onset of symptoms the better the results.

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CANCER CONTROL EDUCATION RECOMMENDED

A joint committee on health problems in education from the National Education Association and the American Medical Association, meeting in Chicago recently, adopted a statement pointing out that cancer control is a major health problem in the United States and that as such it merits attention not only in research but also in education. The committee recommended that instruction concerning the nature of cancer and known methods of prevention and control be included in the high school course of study.

CORNEAL TISSUE PRESERVATION LIMITED

Corneal tissue will remain clear and of normal thickness and can be used suitably for transplantation up to a period of three days, reports Dr. Charles I. Thomas, Department of Surgery, Division of Ophthalmology, Western Reserve University School of Medicine, Cleveland, in the September, 1946, issue of *Archives of Ophthalmology*. After experimenting with six different preservative mediums, Dr. Thomas concluded that the tissue becomes progressively hazy and thickened after three days and is thus unsuitable for grafting.

A COMPARISON OF TWO CHOLECYSTOGRAPHIC MEDIA

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This report will give the results of a clinical, roentgenologic, and surgical study on the use of two cholecystographic media, namely, tetraiodophenolphthalein and B-(4-hydroxy-3, 5-diiodophenyl)-α-phenyl-propionic acid. The phenolphthalein compound used was a product of a leading pharmaceutical concern while the propionic acid compound was furnished in part by the Schering Corporation and called Priodax.

Previous reports have emphasized the advantages of Priodax, but no actual comparison of the two media has been reported except for a series by Paul, Pohle, and Benson.[7] With such a comparison in mind, 1,000 consecutive patients were chosen in whom the first 500 were given tetraiodophenolphthalein while the next 500 received Priodax. The tetraiodophenolphthalein was given in 4 Gm. doses with strict following of Kirklin's[5] recommendations in regard to diet, time, preparation, and roentgenographic technique. The Priodax was given in 3 Gm. doses following the procedure recommended by the Schering Corporation. All patients were questioned during the morning of the gallbladder examination in regard to their symptoms.

CHART 1. *Reactions to Priodax as Reported in the Literature.*

Authors	Nausea	Vomiting	Diarrhea	Burning on Urination
Bryan and Pederson 245 cases	20%	2%	30%	12%
Hefke 600 cases	occasional	0.08%	11%	3% in 100 males 0% in females
Einsel and Einsel 50 cases	0	0	0	0
Dannenburg 143 cases	0	3%	0	0
Marshall 50 cases		0.5%	0.5%	1%
Wasch 134 cases	18%	0%	13%	2%

The major symptoms caused by the two media are nausea, vomiting, diarrhea, and burning on urination. Chart 1 shows the frequency of these symptoms as reported by different authors. It is noted that there is a wide variation in the percentage of nausea, vomiting, diarrhea, and burning on urination.

To investigate the symptoms of all patients, we decided to question them about nausea, vomiting, diarrhea, burning on urination, abdominal cramps, headache, backache, burning in the throat, bad taste in the mouth, insomnia, and general malaise. We attempted to grade the symptoms on the basis of severity so that grade 1 would represent a symptom of minimal amount while grade 4 would indicate a severe reaction.

CHART 2. *Reactions to Tetraiodophenolphthalein and to Priodax.*

(500 Cases) Tetraiodophenolphthalein			(500 Cases) Priodax		
Reaction	Cases	Grade	Reaction	Cases	Grade
Nausea	106	1	Nausea	88	1
	125	2		62	2
	110	3		22	3
	30	4		7	4
Vomiting	12	1	Vomiting	4	1
	4	2		6	2
	4	3		2	3
	1	4		0	4
Diarrhea	106	1	Diarrhea	103	1
	100	2		55	2
	76	3		20	3
	30	4		13	4
Burning on Urination	16	1	Burning on Urination	67	1
	8	2		61	2
	3	3		40	3
	0	4		42	4
Abdominal Cramps	74	1	Abdominal Cramps	54	1
	91	2		45	2
	46	3		14	3
	9	4		6	4
Headache	18	1	Headache	10	1
	19	2		12	2
	7	3		3	3
	0	4		0	4
Burning in Throat	28	1	Burning in Throat	2	1
	20	2		7	2
	15	3		0	3
	6	4		1	4
Bad Taste	56	1	Bad Taste	37	1
	105	2		41	2
	40	3		6	3
	10	4		2	4
Backache	10	1	Backache	4	1
	5	2		0	2
	2	3		0	3
	0	4		0	4
Insomnia	29	1	Insomnia	8	1
	62	2		3	2
	23	3		1	3
	5	4		2	4
General Malaise	82	1	General Malaise	62	1
	158	2		43	2
	95	3		15	3
	10	4		6	4
Other Reactions (Including faintness, dizziness, supra-pubic pains, etc.)	1	1	Other Reactions	10	
	6	2			
	9	3			
	5	4			
No Reactions in 29 Cases			No Reactions in 109 Cases		

Grades 2 and 3 indicate corresponding grades between 1 and 4.

Chart 2 gives the findings for both media. We soon found that our percentages of reactions were quite a bit higher than those reported in the literature. It is well known that it is difficult to define the term "diarrhea," and the evaluation of nausea is also somewhat complicated. We decided that for

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diarrhea to be listed as a symptom, the patient must have had two or more loose stools after taking the media in order for the symptoms to be listed as grade 1. Before the symptom "nausea" was listed as grade 1, the patient had to complain of a definite feeling of a "sick stomach." Since we used the same criteria for symptoms with both media, we believe that a comparison can be made; however, the low incidence of symptoms caused by Priodax, as reported in the literature, leads us to believe that these authors only listed the more severe reactions.

Chart 3 was compiled by using the figures from charts 1 and 2. A percentage analysis of the reactions caused by the two cholecystographic media is presented as well as average percentage figures from the cases reported in the literature. It will be noted from chart 3 that Priodax produced almost 50 per cent less of all symptoms listed except for burning on urination and burning in the throat. Forty-two per cent of all patients who received Priodax complained to some degree of burning on urination, and this has been the outstanding complaint. We concluded from chart 3 that as far as the patient is concerned, Priodax is a much preferable medium for cholecystography except for the high instance of burning on urination.

CHART 3. *Analysis of Reactions to Tetraiodophenolphthalein and to Priodax.*

	Tetraiodophenolphthalein 500 Cases	Priodax 500 Cases	Priodax 1,222 Cases from the Literature
Nausea	74%	35%	6%
Vomiting	4%	2%	1%
Diarrhea	63%	38%	9%
Burning on Urination	5%	42%	2%
Abdominal Cramps	44%	23%	
Headaches	8%	5%	
Burning in Throat	13%	17%	
Bad Taste	42%	17%	
Backache	3%	1%	
Insomnia	23%	2%	
General Malaise	69%	25%	

To compare the two media from a radiographic standpoint, the roentgenographic reports were analyzed and chart 4 was prepared. It will be noted that there is very little difference between the two media as far as the roentgenographic diagnosis is concerned. Gas partially obscured the gallbladder image in an equal number of cases, but tetraiodophenolphthalein was present in the hepatic flexure of the colon in 30 instances, or 6 per cent, of the 500 patients who received this medium. In the patients who received Priodax, there was no instance of medium being noted in the colon or small bowel.

Of the 500 patients receiving tetraiodophenolphthalein, 77, or 15 per cent, showed some pathologic change on the roentgenograms, while in the Priodax series, 88, or 17 per cent, had an abnormal roentgenogram. The roentgenologic diagnosis was consistent with the clinical impression in a high percentage of the cases. As was to be expected, the 5 patients who had papillomata had no symptoms.

In the patients receiving tetraiodophenolphthalein, 6 had calculi and no symptoms, while in the Priodax series, 3 with stones had no symptoms.

CHART 4. *Roentgenographic Analysis of Tetraiodophenolphthalein and Priodax.*

	Tetraiodophenolphthalein	Prioda
Normal visualization	422	412
Poor visualization	11	4
Good concentration with stones	20	30
Poor concentration with stones	6	17
No concentration with stones	14	12
No concentration or stones	24	22
Normal visualization with papillomata	2	3
Gallbladder area obscured by gas	228	227
Gallbladder area obscured by media in bowel	30	0

No concentration of the dye was noted in 3 symptomless patients receiving Priodax, while this apparent error did not occur in the tetraiodophenolphthalein series. We believe that these minor variations between the roentgenologic and clinical impressions are of no significance.

Of the 165 patients who had positive gallbladder roentgenograms, only 19 were operated on. This reflects the conservative handling of cases of chronic cholecystitis in our institution. Twelve of the patients had tetraiodophenolphthalein and 7 received Priodax. There was complete agreement with the roentgenologic, surgical, and pathologic findings in all 19 patients operated on. These surgical and pathologic findings are not of sufficient volume to determine accuracy of the roentgenologic diagnosis, but since this series of 1,000 cases, we have routinely used Priodax in slightly more than 4,000 patients. Surgical findings have confirmed the roentgenologic diagnosis in a very high percentage of all cases, and we feel safe in concluding that Priodax is equally as reliable as tetraiodophenolphthalein. We do not use the double dose method but rely more on a close correlation of the roentgeno-

logic and clinical findings for the doubtful cases. At times we repeat the gallbladder examination, and if a good filling is obtained the second time, we consider that the apparently poor concentration of the medium in the first examination was due to some error in procedure or roentgen technique. Priodax is not used in patients with severe kidney damage.

Paul, Pohle, and Benson in their series of 114 patients who received Priodax found 28 per cent complained of nausea, 1.7 per cent of vomiting, 22.8 per cent of diarrhea, and 15 per cent of burning on urination. These percentages closely followed our results except for burning on urination. This symptom was present in 42 per cent of our patients who received Priodax. These authors also noted no difference in the density of the two media on the roentgenograms, and also did not find the intensified dose method to be of any marked value.

Paul, Pohle, and Benson acknowledged their observations to be at variance with the majority of the reports in the literature, and in our 1,000 cases there was a fairly close agreement with their findings. We did not include their series of 114 patients who received Priodax in our statistics of other authors for the reason that our results closely paralleled theirs, and both reports are at variance with the majority of other recorded experiences.

CONCLUSION

1. As far as the patient is concerned B-(4 hydroxy-3, 5-diiodophenyl)-α-phenyl propionic acid (Priodax) is a more preferable medium for cholecystography than tetraiodophenolphthalein.

2. As far as the radiologist, clinician, and surgeon are concerned, Priodax is equal in reliability to the time-tested tetraiodophenolphthalein.

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8. Wasch, M. G.: A New Medium for Gallbladder Visualization, Am. J. Roentgenol. 50:677-679 (Nov.) 1943.

ABSTRACT OF DISCUSSION

Dr. Palmer E. Wigby, Houston: Drs. Stevenson and Smith have presented useful information concerning cholecystographic media as a result of painstaking effort. It is clinical investigative data of this kind which are necessary to medical progress and we are all grateful that men in our own community are able and willing both to carry out the work and then deduce conclusions which will be of value to radiologists and thus the profession as a whole.

I have not tabulated any consecutive large series of cases on the side symptoms of any cholecystographic medium. I did correlate a series of 200 consecutive cases at Parkland Hospital in Dallas in about 1937 with the clinical findings. We were using iodeikon by mouth almost exclusively. In that series 1 case visualizing normally showed several very minute calculi at operation within an essentially normal gallbladder, and 1 other case showing nonvisualization revealed a normal gallbladder to palpation at operation. This latter patient was in the psychopathic ward and we strongly suspected that she did not take the dye although she knew gallbladder symptoms well enough to prompt the surgeon to post her for cholecystectomy. He did not remove the gallbladder. Other than in these 2 cases, the roentgenologic findings were consistent with the clinical findings in every case.

When I first started using Priodax in my office in Houston I inquired of every patient personally for several weeks about side symptoms. It seemed to me that there were practically no complaints. I recall one large heavy man, to whom I had given 12 tablets, stating that he had diarrhea almost all night. Since receiving Drs. Stevenson and Smith's paper I listed the symptoms on a chart and had the technicians ask each gallbladder patient about each symptom, telling them that diarrhea meant at least two loose, somewhat liquid stools, during the night after taking the tablets. The tabulation shows diarrhea as a complaint in every case except 1; that patient stated hers was slight, meaning one or two soft stools. The only conclusion I could draw from that small study of about 30 cases is that the dye is causing more side symptoms now than it did when it first came out. The same was true for burning on urination, except that symptom is not as frequent as diarrhea. Nausea and vomiting were conspicuously infrequent. I realize these conclusions may well be highly inaccurate inasmuch as I talked to the first group of patients myself and the second recent group were questioned almost entirely by different technicians. Nevertheless, I still feel that Priodax is an improvement over the old preparations and I intend to continue to use it until something definitely better is presented.

Dr. Roy G. Giles, San Antonio: In my experience Priodax is a much less toxic contrast medium than sodium tetraiodophenolphthalein. Due to the toxic effects which sometimes follow the use of sodium tetraiodophenolphthalein in adults, very few references are to be found in the literature on cholecystography in children. John Caffey* stated, "In the few cholecystograms we have attempted in infants and children younger than 3 years, satisfactory gallbladder shadows have not been demonstrable." Hrdlicka, Watkins, and Robb† reported cholecystography in 47 unselected children. They were of the opinion that Priodax was a satisfactory contrast medium for children over 9 months of age. The toxic effects were minimal in young infants, and the dosage required in some cases was even 1.5 Gm. per 10 Kg. of body weight. The ordinary dose of 0.5 Gm. per 10 Kg. of body weight was sufficient for children 4 years of age or older.

*Pediatrics, X-Ray Diagnosis. Chicago, Year Book Publishers. 1945, p. 402.
†Am. J. Dis. Child. 70:325-328 (Nov.-Dec.) 1945.

From time immemorial man has considered health as his rightful heritage, and has therefore resented disease as a misfortune visited upon him by malignant external influences.—Edward J. Stieglitz, M. D., A Future for Preventive Medicine, The Commonwealth Fund, 1945.

CANCER OF THE LARYNX, ITS DIAGNOSIS AND TREATMENT

CLAUDE C. CODY, JR., M. D.
HOUSTON, TEXAS

Diagnosis is the first step in the treatment of disease. This axiom is particularly applicable to carcinoma of the larynx, for early accurate diagnosis of laryngeal cancer with appropriate therapy has converted a previously incurable condition with a mortality rate of 100 per cent to one of approximately 15 per cent. The incidence of cancer of the larynx seems to be increasing. The explanation for this is the increasing average length of life and more accurate diagnosis. Cancer of the larynx is now, in my experience, diagnosed much more frequently than laryngeal tuberculosis and syphilis. This is quite different from the ratio between these conditions twenty-five years ago. Cancer of the larynx ranks sixth among the cancerous conditions. In England, twenty deaths from cancer of the stomach occur to one of the larynx; while in the United States, there are forty deaths from cancer of the stomach to one of the larynx. It is uncertain whether this means more cancer of the larynx in England than in the United States, or better treatment of laryngeal cancer in this country.

Cancer of the larynx can be diagnosed as early as cancer of the skin, for hoarseness is the earliest and most persistent symptom of carcinoma of the vocal cords. Of all symptoms the most frequent is headache and the next is hoarseness. The frequency of hoarseness in the common disorders and its occurrence in a multiplicity of diseases is conducive to neglect by the patient as well as the doctor. Simply to say that hoarseness is an early symptom of cancer of the vocal cords is of no help in the early diagnosis of the condition. Something more is needed, for hoarseness ranks second among the symptoms and compared to the common diseases cancer of the larynx is relatively rare. The laws of physics, such as the law of gravity, and the laws of chemistry are merely crystallized experience. In this sense, it may be accepted as a dictum, as a law in diagnosis, that any patient with hoarseness persisting as long as two weeks is entitled to an examination of the larynx, for hoarseness plus the time factor of two weeks is the equivalent of an early diagnosis. Pain radiating to the ear, the wheezy cough, difficulty in breathing, pain on swallowing, fetid breath, and persistent pain are all late symptoms.

It is a general diagnostic law that the presenting symptom is dependent on the location of the disease. Carcinoma of the vocal cords, intrinsic cancer, has the early presenting symptom of hoarseness, but the presenting symptoms of extrinsic cancer of the larynx are all late. Cancer of the tissue anterior to the epiglottis, of the epiglottis itself, of the medial surface of the pyriform sinus, of the mucosa over the signet portion of the cricoid, and of the subglottis have no common characteristic symptom save that of late appearance. The first indication of cancer of the so-called bursa of the epiglottis may be a metastasis to the cervical glands or a fungating mass at the base of the tongue with persistent pain. The presenting symptom of cancer of the pyriform sinus may be pain in the ear or usually dysphagia, while that of the subglottis is a cough or dyspnea with a normal voice. The only fortunate thing about extrinsic cancers of the larynx is that they are rare. Extrinsic cancers are so rare that the term "cancer of the larynx" has almost come to mean cancer of the vocal cords. The location of the lesions in their order of frequency is the vocal cords, pyriform sinus, subglottis, epiglottis, and the space anterior to the epiglottis.

Carcinoma of the larynx may appear as an ulcer, as a warty projection, or as a cauliflower mass on one or both vocal cords. The typical appearance of a cancerous ulcer is a shallow irregular saucer with slightly elevated edges vigorously alive on one vocal cord usually in the middle third. The warty projection frequently has an alive appearance probably because of the red streaks. It may be on the medial edge of the vocal cord, but is usually on the upper surface and may occur on the subglottic aspect. Instead of warty projection the cancer may occur as a narrow or relatively broad ribbon with a velvety or plush appearance varying in color from gray to pink to crimson. There seems to be a tendency for the growth to extend anteriorly and cross the midline at the anterior commissure. Also the neoplasm seems to be confined to the mucosa with little tendency to cross the submucosa and invade the vocal muscle until relatively late. In a low grade of malignancy, the cancer cells slowly creep forward in the mucosa from the initial lesion toward the anterior commissure and usually even more slowly to the arytenoids. But in a high degree of malignancy, the extension fairly races to and around the anterior commissure to the other vocal cord, the false cords, and the arytenoids. And then there is the papilloma, a wolf in sheep's clothing. It may have the typical appearance of a papilloma either with a narrow base and slender neck, or flat

Read before the Section on Eye, Ear, Nose, and Throat, State Medical Association of Texas, Annual Session, Galveston, May 8, 1946.

with a broad base and no neck, or a part of the tumor may be typical papilloma except for an ulcerated area with red streaks. A relation between the malignancy of the tumor and its location in the anterior, mid, or posterior third of the vocal cord has not been demonstrated. The fixed arytenoid, usually with an edematous mucosa, is demonstration enough that the cancer has broken through the submucosal barrier and invaded the muscles, and so entirely changes the prognosis and treatment.

The differential diagnosis between pachydermia, tuberculosis, syphilis, and cancer of the larynx is not so easy on the patient as it is on paper. The roentgen examination of the lungs to rule out tuberculosis and metastasis is of course obligatory. It has been my unhappy experience that the serologic tests for syphilis of the larynx are not reliable. The biopsy is necessary to make a definitive differential diagnosis between cancer, syphilis, tuberculosis, and pachydermia. This is readily done with the direct laryngoscope and punch forceps under local anesthesia.

Broders' classification of cancer cells into four groups as an indication of their relative malignancy has proved to be satisfactory in carcinoma of the larynx. The basis of the grouping is the ratio of undifferentiated cells to the differentiated with the percentage of the undifferentiated cells determining the group. Thus in group 1, the undifferentiated cells are 25 per cent of the whole; group 2, 50 per cent; group 3, 75 per cent; and group 4, 100 per cent. In carcinoma of the larynx, this grouping is not of mere academic interest but is quite practical, for Broders' classification is as yet the best indication of the cancer cell's sensitivity to irradiation, with group 1 the least, graduated to group 4 the most sensitive. The clinical application of this pathological observation is in the selection of the treatment of choice for cancer of the larynx. The general rule is the more malignant the cancer the more sensitive to irradiation and the less amenable to surgery. Consequently, roentgen therapy is the method of choice in all cases of group 4, while surgery is indicated in groups 1, 2, and 3.

Papilloma of the larynx in the child is regularly a benign tumor and becomes dangerous only when it reaches a sufficient size to obstruct breathing. But papilloma of the larynx in the adult, either young or old, is always potentially serious. The reason for this is that the cancerous basal cells, carcinoma baso-cellulare, occur only very rarely in the papillomata of the larynx in children, but are frequently deep in the base of flat papillomata in the adult. The lip of the laryngeal punch forceps must be pressed in firmly in doing a biopsy on a clinical papilloma and even then the layer of cancerous basal cells deep in the base of the neoplasm is not infrequently missed. A recurring papilloma of the larynx, sometimes referred to as endothelioma, is cancer until proven otherwise.

The method of choice in the treatment of laryngeal cancer is dependent on many factors, for no one method is equally efficient in all cases. The duration of the disease, the location, size, and degree of malignancy of the tumor, the age and general health of the patient are all factors to be considered in selecting the method of treatment. The treatment must be designed to meet the needs of the patient. An illustration of this dictum is my experience with a man 81 years of age with diabetes and the history of several bouts with coronary thrombosis, hoarseness persisting for seventeen days, and a cancer about 3 mm. in diameter on the subglottic surface of the right vocal cord. Under local anesthesia, a broad tipped electro-cautery white hot through the laryngoscope destroyed the cancer with one touch. The wound healed in two weeks and the patient had no recurrence before his death two and one-half years later from angina pectoris.

Patients with group 4 carcinoma should be irradiated in accordance with the Chutard technique. Surgery does not have a brilliant record with very malignant cancer even when the operation is performed early. The Cutler technique of heavy dosage of roentgen rays applied within a period of seven days is designed as an answer to the harassing question of whether radiation or surgery is the better in a particular case. Broders' classification even in the hands of a highly competent pathologist is not infallible and Cutler's technique offers the proof of the efficacy of the roentgen rays in curing the cancer, for if the neoplasm has completely disappeared within two weeks after the use of roentgen rays by the Cutler technique a cure is almost assured. However, if the tumor has not completely disappeared within three weeks of Cutler's technique, an operation must be done during the fourth week. The operative wound heals promptly during the fourth week after irradiation; but thereafter it progressively heals more slowly. Surgery a year or more after irradiation is almost contraindicated because the wound usually fails to heal.

It seems advisable to dessicate or fulgurate the base of laryngeal papilloma, particuarly the flat type, in the adult, after its removal with the punch. This cauterization is

an additional factor of safety in assuring the destruction of the carcinoma baso-cellulare so frequently present in the base of papilloma. Also, there seems to be a place for dessication in the early cases of cancer with an ulcer no larger than 4 mm. A practical hypothesis is that cancer cells extend not more than 5 mm. beyond the edge of an ulcer confined to a motile vocal cord. The dessication of an early and small cancerous ulcer completely destroys the cancer with minimal damage to the vocal cord and maximal preservation of the voice. The method of dessication in cancer of the larynx has a sharply limited field and is not applicable to medium and large ulcers.

Local anesthesia is quite satisfactory in thyro-fissure and in laryngectomy, but sodium pentothal is preferable when operating after radiation with the Chutard technique. This is particularly true in radiation perichondritis with abcess formation. Sodium pentothal does not control the cough reflex but this can be done by the topical application of cocaine after opening the trachea. Thyro-fissure was introduced by St. Clair Thompson and consists of splitting the thyroid cartilage in the midline and removing the affected vocal cord. Thyro-fissure is indicated when the neoplasm is confined to one vocal cord that is motile, that is without fixation of the arytenoid. It may be used even if the tumor extends beyond the anterior commissure as much as 5 mm. The present technique of the laryngectomy and the equally important postoperative care is a surgical evolution with the object of controlling hemorrhage, preventing infection, and reducing mortality. A laryngectomy is indicated where the tumor is confined to one vocal cord with fixation of the arytenoid, involves both vocal cords, or the entire larynx. It does not seem to make any difference whether the epiglottis is removed or not, nor is the operation facilitated by sectioning or removing the hyoid bone, unless the Vasconcelos-Baretto clamp is used.

Thanks to penicillin and the sulfonamides, the healing of a wound after thyro-fissure and laryngectomy is frequently by primary intention except where radiation has been used. Here sloughing is almost invariable with healing by granulation—if it occurs. The improvements in the technique of treatment during the past thirty years have had a profound effect on rates of mortality and recurrence. But lowering the mortality and recurrence rates is not the result so much of improved technique as to the most important factor of all—early diagnosis. The chief credit for early diagnosis, paradoxical as it may seem, must be given to the alert and conscientious general practitioner, and not to the laryngologist. Unless the general practitioner refers the patient to him, the laryngologist almost invariably sees these patients in the late and not in the early stage. It is literally true that the life of a patient with carcinoma of the larynx is in the hands of the first physician he consults. The patient whose doctor observes the dictum that a person hoarse for fourteen days is entitled to a laryngeal examination rather promptly gets well and in more than 90 per cent of the patients may stay well, provided, of course, that the laryngologist who first inspects the larynx sees the anterior commissure and advises a biopsy to provide a quick and reasonably certain answer to any suspicious pathologic condition. A cancerous patient who is not examined early, or is examined early but not thoroughly, either has a mutilating operation or is dead in two years, and not infrequently experiences both. The general practitioner holds the key position in the early diagnosis of carcinoma of the larynx and the first laryngologist to inspect the larynx determines the efficiency of the treatment.

1304 Walker Ave.

ABSTRACT OF DISCUSSION

Dr. E. H. Cary, Dallas: After reading the interesting paper of Dr. Cody, I think it would be a repetition of thought if I attempted to discuss his paper in detail, but since the key to what can be done for cancer of the larynx is an early diagnosis, I think the first and last sections contain the most important contribution this paper offers.

If we are able to stimulate the interest of the general practitioner so that he will never forget the importance of a person remaining hoarse for the period of time outlined, two weeks, without having him visit a laryngologist who possesses the facilities of making a correct inspection of the larynx, then I am sure we will see persons suffering from cancer which is not difficult to cure.

Cancer located in any part of the body is a very tricky disease and, while it is important to have knowledge of Broders' classification and the character of treatment which it leads one to adopt, it is nevertheless true that clinically we have seen cancer ever so innocent looking rapidly metastasize and become incurable, whereas we have also seen a very distressing situation recognized as cancer, which had been mishandled, grown extensively, and yet was still circumscribed. I agree in toto with the essayist's treatment of this condition and I am quite certain that group 4 type, in spite of what I have just said, deserves the most experienced roentgen ray service that can be had.

I am inclined to think the roentgenologist's knowledge and use of his armamentarium is quite as important as a surgeon with good surgical technique. Until Chutard outlined his treatment, I think the roentgenologists were groping.

There are many other things one could say about Dr. Cody's paper but I think it will stand on its own merits.

Dr. A. F. Clark, Sr., San Antonio: Differential diagnosis of lesions within the larynx becomes easier with experience. Compared to other anatomical areas

attacked by cancer, the larynx is comparatively easy to examine. The experienced eye makes the diagnosis of cancer of the larynx by repeated careful indirect examination in the majority of cases. A confirmation biopsy must follow.

I am not fully convinced that we should accept the term "precancerous lesion." Indeed the more experienced laryngologist in conjunction with a specially trained pathologist often gets a positive biopsy for carcinoma of the vocal cord immediately following a negative examination by the lesser trained physician.

As indicated by Dr. Cody, there is a grave responsibility to the patient with laryngeal carcinoma by the physician in charge. The latter should be a thoroughly trained laryngologist who in turn seeks the necessary aid from other fields of medicine. He must be prepared to carry out the indicated surgery to eradicate the lesion as soon as possible following positive biopsy. For this reason a previous physical survey should have been made.

In my locality many patients come too late for curative surgery. This especially applies to patients referred from Mexico.

Dr. Louis Daily, Houston: Dr. Cody touched upon many phases of this vital subject—malignancies of the larynx. It takes a student and a scholar of Dr. Cody's caliber to present so much material in such a short paper. One should not rely too much upon roentgen ray treatment. It may cause the growth to disappear almost entirely and to re-appear in a few months worse than ever. There is a diversity of opinion about combining surgery and roentgen therapy. Year before last I did a laryngo fissure in a case where all the indications were favorable for this type of operation. I removed a border of normal tissue along with the tumor mass, which was substantiated by serial sections. To make it doubly safe a few weeks following surgery the patient was given a course of roentgen ray treatment. Except for his husky voice he made a complete recovery and resumed his occupation as a construction engineer. Subsequently he developed a severe roentgen ray burn of the esophagus and laryngo-pharynx.

Dr. Cody mentioned sodium pentothal for intralaryngeal surgery. I usually do my work under local anesthesia, cocaine, and adrenalin. But in soft small tumors this will cause shrinking so that the surgeon can hardly see the tissue to be removed. Ether spray is contraindicated if one uses the cautery. In these cases sodium pentothal is the ideal anesthetic, but it is very difficult to get a good exposure of the larynx with sodium pentothal. Sometimes it produces a spasm and a contraction of the muscles of the neck.

The late Dr. M. G. Lynch, of New Orleans, used chloroform spray in this type of case. Most anesthetists are afraid to use it.

MISCELLANEOUS

COMING MEETINGS AND CLINICS

State Medical Association of Texas, Dallas, May 5-8, 1947. Dr. C. C. Cody, Jr., Houston, President; Dr. Holman Taylor, 1404 W. El Paso St., Fort Worth 3, Secretary.

American Medical Association, House of Delegates, Chicago, December 9-11, 1946; Regular General Session, Atlantic City, N. J., June 9-13, 1947. Dr. Harrison H. Shoulders, Nashville, Tenn., President; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secretary.

Southern Medical Association. Dr. M. Y. Dabney, Birmingham, Ala., President; C. P. Loranz, Empire Building, Birmingham, Ala., Secretary-Manager.

Southwest Allergy Forum, Shreveport, La., March 31-April 1, 1947. Dr. W. H. Browning, Shreveport, La., President; Dr. Sim Hulsey, Medical Arts Bldg., Fort Worth, Secretary.

Texas Association of Medical Anesthetists, Dallas, May 5, 1947. Dr. Claudia Potter, Temple, President; Dr. Russell Bonham, Box 6237, Houston, Secretary.

Texas Association of Obstetricians and Gynecologists, Fort Worth, November, 1947. Dr. J. E. Kanatser, Wichita Falls, President; Dr. Julius McIver, 714 Medical Arts Building, Dallas, Secretary.

Texas Chapter, American College of Chest Physicians, May 5, 1947. Dr. R. G. McCorkle, San Antonio, President; Dr. Elliott Mendenhall, 1217 Medical Arts Bldg., Dallas, Secretary.

Texas Club of Internists. Dr. Alvis E. Greer, Houston, President; Dr. Julian C. Barton, 414 Navarro St., San Antonio, Secretary.

Texas Hospital Association, Houston, March 27-29, 1947. Tol Terrell, Harris Memorial Methodist Hospital, Fort Worth, President; Mrs. Ruth Barnhart, 2210 Main St., Dallas, Secretary.

Texas Neuropsychiatric Association, Dallas, May 5, 1947. Dr. Fred T. Rogers, Dallas, President; Dr. David Wade, 604 Capital National Bank Bldg., Austin, Secretary.

Texas Ophthalmological and Otolaryngological Society, Dallas, December 6-7, 1946. Dr. C. H. Brooks, Waco, Acting President; Dr. E. D. Dumas, 425 Medical Arts Bldg., San Antonio, Secretary.

Texas Orthopedic Society. Dr. E. A. Cayo, San Antonio, President; Dr. Edward Smith, 1215 Walker Ave., Houston, Secretary.

Texas Pediatric Society, Houston, October, 1947. Dr. J. R. Lemmon, Amarillo, President; Dr. John E. Ashby, 3610 Fairmount, Dallas, Secretary.

Texas Public Health Association, Dallas. Dr. L. P. Walter, Austin, President; Mr. Earle W. Sudderth, Dallas County Health Department, Court House, Dallas, Secretary.

Texas Radiological Society, Houston, January 25, 1947. Dr. Herman Klapproth, Sherman, President; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secretary.

Texas Railway and Traumatic Surgical Association, May 5, 1947, Dr. F. L. Snyder, Fort Worth, President; Dr. Ross Trigg, First National Bank Bldg., Fort Worth, Secretary.

Texas Society for Mental Hygiene, San Antonio, April 10-12, 1947. Dr. Jack R. Ewalt, University of Texas Medical Branch, Galveston, President; Mrs. Elizabeth F. Gardner, 1617 Watchhill Road, Austin 21, Executive Secretary.

Texas Society of Gastro-Enterologists and Proctologists, Dallas, May 5, 1947. Dr. Tom E. Smith, Dallas, President; Dr. D. L. Curb, 704 Dallas Ave., Houston, Secretary.

Texas Society of Pathologists, Houston, January 28, 1947. Dr. May Owen, Fort Worth, President; Dr. C. T. Ashworth, Southwestern Medical College, Dallas, Secretary.

Texas State Heart Association, Dallas, May 5, 1947. Dr. Robert M. Barton, Dallas, President; Dr. M. B. Whitten, Medical Arts Bldg., Dallas, Secretary.

Texas State Urological Society, Houston, December 2, 1946. Dr. Joe C. Alexander, Dallas, President; Dr. Michael K. O'Heeron, 901 Medical Arts Bldg., Houston, Secretary.

Texas Surgical Society, Dallas, April, 1947. Dr. Walter Stuck, San Antonio, President; Dr. Truman G. Blocker, University of Texas Medical Branch, Galveston, Secretary.

Texas Tuberculosis Association. F. K. Dougharty, Liberty, President; Miss Pansy Nichols, 700 Brazos, Austin, Executive Secretary.

Third, Panhandle, District Medical Society, Amarillo, April 8-9, 1947. Dr. W. A. Carroll, Claude, President; Dr. George Powers, Fisk Bldg., Amarillo, Secretary.

Fourth District Medical Society, Coleman, 1947. Dr. Glenn H. Ricks, Brady, President; Dr. J. C. Young, Coleman, Secretary.

Seventh, Austin, District Society. Dr. Robert B. Morrison, Austin, President; Dr. M. I. Brown, Capital National Bank Bldg., Austin, Secretary.

Eighth, Ninth and Tenth Districts Medical Society, Orange, April, 1947. Dr. Walter F. Hasskarl, Brenham, President; Dr. George W. Waldron, Medical Arts Bldg., Houston, Secretary.

Eleventh District Society. Dr. L. L. Travis, Jacksonville, President; Dr. C. B. Young, 929 S. Confederate, Tyler, Secretary.

Twelfth, Central Texas, District Society, Temple, January 14, 1947. Dr. Thomas G. Glass, Marlin, President; Dr. H. F. Connally, Jr., Amicable Bldg., Waco, Secretary.

Thirteenth, Northwest District Society, Abilene, Spring, 1947. Dr. Frank Hodges, Abilene, President; Dr. Robert C. Stokes, 501 First National Bank Bldg., Fort Worth, Secretary.

Fourteenth District Society, Dallas, December 10, 1946. Dr. C. B. Thayer, Gainesville, President; Dr. V. L. Tuck, Sherman, Secretary.

Fifteenth, Northeast Texas, District Society. Dr. Joe Roberts, Longview, President; Dr. S. W. Tenney, Marshall, Secretary.

CLINICS

Dallas Southern Clinical Conference, Dallas, March 17-20, 1947. Miss Thelma J. Webb, 1133 Medical Arts Bldg., Dallas 1, Executive Secretary

International Postgraduate Medical Assembly of Southwest Texas, San Antonio, January 28-30, 1947. Dr. A. Fletcher Clark, 827 Medical Arts Building, San Antonio, President.

New Orleans Graduate Medical Assembly, New Orleans, February 24-27, 1947. Dr. Max M. Green, Room 105, 1430 Tulane Ave., New Orleans 13, Secretary.

Post Graduate Medical Assembly of South Texas, Houston, December 3-5, 1946. Secretary, 229 Medical Arts Building, Houston.

MEDICAL OFFICERS RETURNING TO TEXAS*

NAME	Serv.†	Location	Release Date
Austin-Waller Counties			
4. Shindler, Thomas O.	A	Hempstead	
Bell County			
18. Halley, Bonnie C., Jr.	N	Temple	
19. Robinson, James E., Jr.	N	Temple	
Bexar County			
157. Garren, John T., Jr.	A	San Antonio	
158. Jackson, Dudley, Jr.	A	San Antonio	
159. Jensen, Andrew M.	A	San Antonio	
160. Manhoff, Charles M.	A	San Antonio	
161. May, Henry K.	N	San Antonio	
162. Nixon, Robert R.	A	San Antonio	
Bosque County			
4. Goodall, Edwin	N	Valley Mills	
Brazoria County			
5. Skarke, Edward A.	A	Freeport	
Brazos-Robertson Counties			
9. Walton, Thomas O., Jr.	N	College Station	
Cameron-Willacy Counties			
20. Bleakney, Philip A.	N	Harlingen	
21. Celaya, Albert	A	Brownsville	
22. Dodd, George, Jr.	N	Brownsville	
23. Garcia, Joseph I., Jr.	N	Brownsville	
24. Myers, Gordon S.	N	Brownsville	
Clay-Montague-Wise Counties			
6. Tyler, Joe E.	A	Ringgold	
Coryell County			
6. Koerner, Theodore A.	A	Gatesville	
Dallas County			
226. Abrams, Raymond H.	A	Dallas	
227. Addison, Jack J.	N	Dallas	
228. Bornstein, David M.	A	Dallas	
229. Harkins, James E.	A	Dallas	
230. Jackson, Harvey K.	A	Dallas	
231. Kaplan, Harry L.	N	Dallas	
232. Kidd, Frank H., Jr.	A	Dallas	
233. King, Carey G., Jr.	N	Dallas	
234. Lee, James F.	N	Dallas	
235. Payne, Virgil M., Jr.	N	Dallas	
236. Terry, Jay G.	A	Dallas	
Denton County			
7. Holland, Joseph W.	A	Denton	
DeWitt County			
5. Nowierski, Leon W., Jr.	N	Yorktown	
6. Pridgen, James E.	A	Cuero	
El Paso County			
64. Black, Gordon L.	N	El Paso	
65. Blanco, Victor M.	N	El Paso	
66. Craige, Branch	A	El Paso	
67. Davis, Roy N.	A	El Paso	
68. Nutnick, Reuben	U	El Paso	
69. Phillips, Richard J.	A	El Paso	
70. Stampfli, Frank V.	N	El Paso	
Erath-Hood-Somervell Counties			
6. Mulloy, Mary E.	A	Stephenville	
Falls County			
9. Hutchins, Selwyn P. R.	N	Marlin	
Galveston County			
62. Jaynes, Stanley H.	A	Galveston	
63. Stiernberg, Royall C.	N	Galveston	
64. Wilson, Charles M., Jr.	N	Galveston	
Grayson County			
15. Essin, Emmett M., Jr.	N	Sherman	
Gregg County			
17. Bruce, Elmer I., Jr.	N	Longview	
Hale-Floyd-Briscoe-Swisher Counties			
9. Harmon, Franklin C., Jr.	A	Floydada	
Harris County			
278. Boice, Edward H.	A	Houston	
279. Etter, Richard L.	A	Houston	
280. Hardy, Sidney B.	N	Houston	
281. Jester, Albert W.	N	Houston	
282. Knight, Wm. R., III	A	Houston	
283. Lamberth, Ivey E.	A	Houston	
284. Leonard, Russell J.	N	Houston	
285. McKay, James V.	A	Humble	
286. Miller, Samuel I.	A	Houston	
287. Norris, Ronald F.	N	LaPorte	
288. Sherrill, William M.	A	Houston	
289. Snyder, Hal	A	Houston	
Harrison County			
10. Padgett, Harold O.	N	Marshall[1]	
Hidalgo-Starr Counties			
12. Barker, Edward C.	N	Mercedes	
13. Mattison, Myron D.	N	Donna	
Hopkins-Franklin Counties			
5. Connor, Marvin M.	A	Cumby	
Hunt-Rockwall-Rains Counties			
17. Lenon, E E	N	Greenville	
18. Smith, John R.	A	Wolfe City	
Jefferson County			
56. Duplan, Don C., Jr.	A	Port Arthur	
57. Pitre, Roy Paul		Port Arthur	Aug., 1946
58. Thompson, James T.	A	Port Arthur	
Kimble-Mason-Menard-McCulloch Counties			
5. Hallum, Basil A., Jr.	N	Brady	
6. Hays, Robert D.	N	Brady	
Lamar County			
10. Anderson, Carter, Jr.	N	Paris	
Lubbock County			
28. Ameen, Ray C.	N	Lubbock	
29. Riddel, Roy L., Jr.	N	Lubbock	
McLennan County			
52. Kochmann, Walter P.	A	Waco	
53. Russo, Galileo M.	A	Waco	
Montgomery County			
2. Wilkins, Afton N.	A	Conroe	
Potter County			
31. Knight, Melvin K.	N	Amarillo	
Randall-Deaf Smith-Parmer-Castro-Oldham Counties			
6. Duflot, Leo S. M.	N	Canyon	
Runnels County			
4. Pearce, John Y.	A	Ballinger	
San Patricio-Aransas-Refugio Counties			
11. Woods, Haddon B.	A	Refugio	
Scurry-Dickens-Kent-Garza-Borden-King-Stonewall Counties			
9. Alexander, Arthur B.	A	Spur	
Smith County			
16. Clawater, Earl W., Jr.	N	Tyler	
17. Eisen, Herman M.	A	Tyler	
18. Thompson, Cone J., Jr.	A	Tyler	
Tarrant County			
85. Eldridge, Irving C.	A	Fort Worth	
86. McBride, James O.	N	Fort Worth	
87. Mahaffey, Cecil H.	A	Fort Worth	
88. Moyar, John B.	A	Fort Worth	
89. Myers, Theodore B.	A	Fort Worth	
Tom Green-Coke-Crockett-Concho-Irion-Sterling-Sutton-Schleicher Counties			
23. Jones, R. R.	A	San Angelo[2]	
24. Rape, Marvin G.	A	San Angelo	
Travis County			
59. Adkins, Charles F.	N	Austin	
60. Anthony, James M.	N	Austin	
61. Craddock, Wallis L.	A	Austin	
62. Ellison, Alfred, Jr.	N	Austin	
63. Fisher, Charles I.	A	Austin	
64. McCormick, Thaddeus	A	Austin	
65. Seybold, William D.	N	Austin	
66. Taylor, Thomas U., II	N	Austin	
Washington County			
5. Schoenvogel, Clarence W.	N	Brenham	
Wharton-Jackson-Matagorda-Fort Bend Counties			
18. Jenkins, Edward E.	A	Sugar Land	
Williamson County			
7. Kirkpatrick, Roy H.	A	Taylor	
8. Wales, Philip A.	N	Florence	

*EDITOR'S NOTE: This list is the fourteenth of a series in which it is hoped to name all those physicians who have been in the Armed Forces during the war recently passed and have now returned to Texas to resume civilian practice. The information in this list has been assembled from a variety of sources. While an attempt has been made to secure as complete and as accurate data as possible, we are aware that omissions and errors have been made. Not only for publication in the JOURNAL but also for the permanent records in the central office of the State Medical Association, we invite and urge correction of and addition to the material here submitted. Note that physicians from each county area are numbered consecutively following those listed in the November JOURNAL; the last number in each section therefore indicates the total physicians returned to that county area. The complete total for Texas named to date (November 25), including the accompanying list, is 1,956.

†A=Army; N=Navy; U=U. S. Public Health Service.

[1]Formerly of Graham.

[2]Formerly of Midland.

HOSPITALS NEEDING INTERNS AND RESIDENTS

Methodist Hospital, Dallas. Capacity 206 beds. C. B. Fielder, Superintendent (interns desired, July, 1947).

El Paso City County Hospital, El Paso. Capacity 192 beds. George W. Cook, Col., U. S. A., Ret., Superintendent (3 interns for one year term, graduates of class A medical school only).

TEXAS CLUB OF INTERNISTS

The Texas Club of Internists at its fall meeting in Houston, October 18-19, heard a program presented entirely by Houston physicians and scientists in related fields. The program was as follows:

October 18

Surgery of Congenital Heart Disease—Drs. H. T. Barkley and George W. Salmon.

The Newer Concept of Stokes-Adam Syndrome—Dr. Sidney Schnur.

Mercurial Diuretics; Comparison of Cardiac Toxicity in Animals—Drs. Don W. Chapman and Carl F. Shaffer.

Present Status of Folic Acid—Dr. R. A. Hettig.

Rat Bite Fever—Dr. W. M. Fisher.

Production of Cardiac Enlargement in Adrenalectomized Rats by Desoxycorticosterone—J. H. Gast, Sc. D.

Excretion of Fecal Antibodies During Enteric Infection—Dr. P. E. Harrison.

October 19

Case of the Nephrotic State—Dr. F. H. Kilgore.

Hypogonadism—Dr. J. A. Greene.

Hyperspleenism—Dr. M. A. Zionts.

Filariasis and Schistosomiasis—Asa Chandler, Ph. D.

Dr. Alvis E. Greer, Houston, president of the club, entertained at his home the evening of October 18 with a cocktail party for members and their wives.

STATE BOARD OF MEDICAL EXAMINERS

An examination session will be held February 20-22, 1947, at the University of Texas Medical Branch, Galveston, by the State Board of Medical Examiners, announces Dr. T. J. Crowe, secretary of the board.

TEXAS ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS

The seventeenth annual meeting of the Texas Association of Obstetricians and Gynecologists was held in Galveston on November 2, with the largest attendance yet recorded. Seventy-seven members and thirty-eight visitors registered.

The following scientific program was presented:

Welcome Address—Chauncey D. Leake, Ph. D., Vice-President and Dean, University of Texas Medical Branch, Galveston.

Bacteriology of Puerperal Sepsis—Charles E. Lankford, Ph. D., Consultant in Gynecological Bacteriology, John Sealy Hospital, Galveston.

Some Obscure Factors in Human Reproduction—Dr. John Rock, Clinical Professor of Gynecology, Harvard University School of Medicine, Boston.

Study of Calcium of Vulva in John Sealy Hospital—Dr. J. T. Downs, John Sealy Hospital, Galveston.

Psychiatric Aspect of the Menopause—Dr. Herbert Chamberlain, San Francisco.

Clinical Pathological Conference—Drs. Paul Brindley, N. D. Schofield, and Staff, Department of Pathology, and Drs. Hiram P. Arnold, J. T. Downs, Charles H. Nash, Jr., A. J. Jinkins, W. Reed Wood, John D. Weaver, W. R. Cooke, J. J. Delaney, Bernard Perlman, M. A. Caravageli, David L. Traylor, and Staff, Department of Obstetrics and Gynecology, University of Texas Medical Branch, Galveston.

Male Factors in the Barren Marriage—Jules K. Lamar, Ph. D., Consultant in Gynecological Endocrinology, John Sealy Hospital, Galveston.

The Pediatrician's Viewpoint in Some Obstetric Problems—Dr. Virgil Baxter, Instructor in Obstetrics and Gynecology, University of Texas Medical Branch, Galveston.

A Technique for Sterilization—Dr. Willard R. Cooke, Obstetrician-in-Chief and Gynecologist-in-Chief, John Sealy Hospital, Galveston.

The Calvin R. Hannah Lecture: Pelvic Cellulitis—Dr. William F. Mengert, Professor of Obstetrics and Gynecology, Southwestern Medical College, Dallas.

The J. F. Y. Paine Address: Menstrual Disorders and Their Treatment—Dr. John Rock, Boston.

Discussion of Present Methods of Investigation of Sterility—Dr. M. J. Meynier, Jr., Houston.

President's Address: Vaginal Hysterectomy (moving pictures)—Dr. Allen L. McMurrey, Houston.

Early Development of Human Ovum (slides)—Dr. John Rock, Boston.

The Adolescent Impact on the Personality—Dr. Herbert Chamberlain, Sacramento, Calif.

Drs. H. Reid Robinson and J. L. Jinkins, both of Galveston, were chairmen of the arrangements committee and presided at the morning session. Dr. Allen L. McMurrey, Houston, president, and Dr. Julius McIver, Dallas, secretary, presided at the afternoon and evening sessions.

A luncheon for visiting obstetricians and gynecologists was held at John Sealy Hospital through the courtesy of Dr. B. I. Burns, director, and William O. Bohman, superintendent. Mesdames J. L. Jinkins, H. Reid Robinson, Willard R. Cooke, and A. J. Jinkins were in charge of a luncheon at Hotel Galvez for visiting women, at which Mrs. John Rock, Boston, and Mrs. Herbert Chamberlain, San Francisco, were special guests. Thirty-eight women attended. A cocktail hour for physicians and their wives was held at the Buccaneer Hotel preceding dinner, at which the final addresses by Drs. Rock and Chamberlain were delivered.

New members announced at the dinner include Drs. William F. Guerriero, Dallas; Theodore R. Hannon, Houston; Rudolph K. Harlan, Temple; and Horace C. Sweet, San Antonio.

The next meeting will be in Fort Worth in November, 1947. Until that time, the following officers will serve: Drs. J. E. Kanatser, Wichita Falls, president; Warren E. Massey, Dallas, president-elect; Charles A. Smith, Texarkana, vice-president; Julius McIver, Dallas, secretary-treasurer; Milton Davison, Marlin (1947), E. H. Marek, Yoakum (1947), Allen Stewart, Lubbock (1948), J. N. Burditt, Abilene, (1948), Allen McMurrey, Houston (1949), and G. H. Beavers, Jr., Fort Worth (1949), executive council.

The organization is sponsoring an award of $100 for the best paper on obstetrics and gynecology replacing an earlier award of $50, which has been withdrawn. The new contest will be open not only to members of the society but to junior members, physicians eligible for junior membership, and residents in obstetrics and gynecology at accredited hospitals. The award is being given to honor the late Dr. Calvin R. Hannah, Dallas.

A. M. A. SESSION OPEN ONLY TO FELLOWS

The American Medical Association centennial anniversary session in Atlantic City, N. J., June 9-13, 1947, will be open only to fellows of the association and invited guests. The central office staff of the association, 535 North Dearborn Street, Chicago 10, urges that physicians who are not fellows and wish to attend, write now to the Chicago office to check upon their eligibility for fellowship. Primary qualification is membership in a state medical society; dues and subscription to *The Journal of the American Medical Association* are included in an annual payment of $8, which is the cost of *The Journal* to subscribers who are not fellows.

MOTION PICTURES OF PHYSICIANS WANTED

Motion pictures of famous physicians and surgeons of the past are wanted by the American Medical Association in connection with its one hundredth anniversary session in Atlantic City in 1947, announces *The Journal of the American Medical Association.* A special feature of the meeting will be the showing of a film now being prepared of outstanding medical personalities at work or play. Those hav-

ing motion pictures which might be suitable or knowing of such films are invited to submit information about them, including the length of film, whether in color or in black and white, and the circumstances under which the pictures were taken. Original film sent to the Committee on Medical Motion Pictures of the Association will be duplicated and returned to the owner.

BILL PERTAINING TO CORONER'S INQUESTS*

Section 1. That Article 968, Code of Criminal procedure of the State of Texas, 1925, be, and the same is hereby amended to read as follows:

"Article 968. When Held.

"Any justice of the peace shall be authorized, and it shall be his duty, to hold inquests without a jury within his county, in the following cases:

"1. When a person dies in prison or in jail.

"2. When any person is killed; or from any cause dies an unnatural death, except under sentence of the law; or dies in the absence of one or more good witnesses.

"3. When the body of a human being is found, and the circumstances of his death are unknown.

"4. When the circumstances of the death of any person are such as to lead to suspicion that he came to his death by unlawful means.

"5. When any person commits suicide, or the circumstances of his death are such as to lead to suspicion that he committed suicide.

"6. When a person dies without having been attended by a duly licensed and practicing physician, and the local health officer or registrar required to report the cause of death under Rule 41a, Sanitary Code of Texas, Art. 4477, Revised Civil Statutes, General Laws, 46th Leg., 1939, p. 343, does not know the cause of death. When the local health officer or registrar of vital statistics whose duty it is to certify the cause of death does not know the cause of death, he shall so notify the Justice of the Peace of the precinct in which the death occurred and request an inquest.

"7. When a person dies who has been attended by a duly licensed and practicing physician or physicians, and such physician or physicians are not certain as to the cause of death and are unable to certify with certainty the cause of death as required by Rule 40a, Sanitary Code of Texas, Art. 4477, Revised Civil Statutes, Chap. 41, Acts 1st Called Session, 40th Leg., 1927, page 116. In case of such uncertainty the attending physician or physicians, or the superintendent or general manager of the hospital or institution in which the deceased shall have died, shall so report to the justice of the peace of the precinct in which the death occurred, and request an inquest.

"The inquests authorized and required by this article shall be held by the justice of the peace of the precinct in which the death occurred, but in event the justice of the peace of such precinct is unavailable, or shall fail or refuse to act, then such inquest shall be conducted by the nearest available justice of the peace in the county in which the death occurred."

Section 2. That Article 969, Code of Criminal Procedure, 1925, be and the same is hereby amended so as to read as follows:

"Art. 969. Body disinterred or cremated.

"Sec. 1. When a body upon which an inquest ought to have been held has been interred, the justice may cause it to be disinterred for the purpose of holding such inquest.

"Sec. 2. Before any body, upon which an inquest is authorized by the provisions of Article 968, Code of Criminal Procedure, 1925, as herein amended, can be lawfully cremated, an autopsy shall be performed thereon as provided in this Act, or a certificate that no autopsy was necessary shall be furnished by the justice of the peace. Before any dead body can be lawfully cremated, the owner or operator of the crematory shall demand and be furnished with a certificate, signed by the justice of the peace of the justice precinct in which the death occurred showing that an autopsy was performed on said body or that no autopsy thereon was necessary. No autopsy shall be required by the justice of the peace as a prerequisite to cremation in case death was caused by the pestilential diseases of Asiatic cholera, bubonic plague, typhus fever, or smallpox, named in Rule 77, Sanitary Code of Texas, Article 4477, Revised Civil Statutes of Texas, 1925. All certificates furnished the owner or operator of a crematory by any justice of the peace, under the terms of this Act, shall be preserved by such owner or operator of such crematory for a period of two years from the date of the cremation of said body.

"Sec 3. Any person violating any provision of this article insofar as it relates to the cremation of bodies, shall be guilty of a misdemeanor, and upon conviction shall be fined in any sum not less than Five Hundred ($500.00) Dollars and not more than One Thousand ($1,000.00) Dollars, or by imprisonment in the county jail for not more than six months, or by both such fine and imprisonment."

Section 3. That Article 970, Code of Criminal Procedure, 1925, be and the same is hereby amended to read as follows:

"Article 970. Physician Called In.

"Upon an inquest held to ascertain the cause of death, the justice shall in all cases call in the county health officer, or if there be none or if his services are not then obtainable, then a duly licensed and practicing physician, and shall procure their opinions and advice as to the necessity of an autopsy before reaching a determination as to whether or not to order an autopsy to determine the cause of death. If upon his own determination he deems an autopsy necessary, the justice of the peace shall request the county health officer, or if there be none or if it be impracticable to secure his services, then some duly licensed and practicing physician who is trained in pathology, to make an autopsy in order to determine the cause of death, and whether death was from natural causes or resulted from violence, and the nature and character of either of them. The county in which such inquest and autopsy is held shall pay to the physician making such autopsy a fee of not more than One Hundred ($100.00) Dollars, the amount to be determined by the Commissioners' Court after ascertaining the amount and nature of the work performed in making such autopsy."

Section 4. That Article 971, Code of Criminal Procedure, 1925, be and the same is hereby amended to read as follows:

"Article 971. Chemical Analysis.

"If upon such inquest, it becomes necessary to determine whether the death has been produced by poison, the justice of the peace, upon his own determination, or upon request of the physician performing such autopsy, shall call in to his aid, if necessary, some medical expert, chemist, toxicologist or licensed physician practicing pathology, qualified to make an analysis of the stomach and its contents, together with such other portions of the body as may be necessary to be analyzed and tested, for the purpose of determining the presence of poison in such body. The Commissioners' Court shall pay to such expert or specialist such fee as it may determine reasonable, not to exceed One Hundred ($100.00) Dollars."

*A bill to be introduced in the Fiftieth Legislature to correct deficiencies in present Texas statutes pertaining to inquests by justices of the peace. The bill has been approved by the Texas Society of Pathologists and the Executive Council of the State Medical Association. Editorial discussion of the bill may be found on page 457 of this number of the JOURNAL.—Ed.

Section 5. That Article 1053, Code of Criminal Procedure, 1925, be and the same is hereby amended to read as follows:

"Article 1053. Inquest Fee.

"A justice of the peace shall be entitled, for an inquest on a dead body, including certifying and returning the proceeding to the proper court, the sum of Ten ($10.00) Dollars, to be paid by the county. When an inquest is held over the dead body of a State penitentiary convict, the State shall pay the inquest fees allowed by law of all officers, upon the approval of the account therefor by the Commissioners' Court of the county in which the inquest may be held and by the General Manager of the Texas Prison System."

Section 6. That Section 1, H. B. 613, p. 343, General Laws, Regular Session, 46th Legislature, 1939, being a part of the Sanitary Code of Texas, be and the same is hereby amended to read as follows:

"Death without medical attendance.

"That in case of any death occurring without medical attendance, it shall be the duty of the undertaker or person acting as such to notify the local registrar of such death, and when so notified the registrar shall, prior to the issuance of permit, inform the local health officer and refer the case to him for immediate investigation and certification; provided that when the local health officer is not a physician, or when there is no such official, and in such cases only, the registrar is authorized to make the certificate and return from the statement of relatives or other persons having adequate knowledge of the facts: provided further, that if the registrar or the local health officer, as the case may be, is in doubt as to the cause of death, or if the case be one otherwise properly referable to a justice of the peace for inquest into the cause of death, he shall then refer the case to a proper justice of the peace for inquest, investigation, and certification. And the justice of the peace or other proper officer whose duty it is to hold an inquest on the body of any deceased person, and to make the certificate of death required for a burial permit, shall state in his certificate the name of the disease causing death, or, if from external causes, (1) the means of death; and (2) whether (probably) accidental, suicidal, or homicidal; and shall, in any case, furnish such information as may be required by the State Registrar in order properly to classify the death; provided, further, that when a death of any person not a resident of that district, or unknown in that district, occurs, the justice of the peace or person acting as coroner shall secure the finger prints of the deceased and the following physical marks of identification:

"(a) Color of hair
"(b) Color of eyes
"(c) Height
"(d) Weight
"(e) Deformities
"(f) Tattoo marks
"(g) Such other facts as set forth by the State Board of Health as will be of assistance in identifying the deceased.

"The finger prints and the physical identification marks shall be placed on a form prescribed by the State Board of Health, and shall be attached to the death certificate. The State Registrar shall forward to the State Department of Public Safety the report showing the finger prints and other physical marks of identification."

Section 7 (a). Any physician duly licensed under the laws of the State of Texas to practice medicine, who, when an autopsy is ordered by a Justice of the Peace, performs the autopsy in good faith in the belief that the order of autopsy is a valid order, shall not be held liable for damages in event it should be determined that the order of autopsy made by the Justice of the Peace is for any reason invalid.

(b). The provisions of this Act shall not apply to any law suit now pending.

Section 8. Saving Clause.

In the event any section, part of a section, or provision of this Act be held invalid, unconstitutional, or inoperative, this shall not affect the validity of the remaining sections or parts of sections of the Act, but the remainder of the Act shall be given effect as if said invalid, unconstitutional, or inoperative section, or any part of section or provisions, had not been included.

Section 9. Emergency.

The fact that justices of the peace and physicians and chemists are now underpaid for their services in connection with the holding of inquests and the performing of autopsies on dead bodies; the fact that public health officers and registrars of vital statistics information now have no means of ascertaining the cause of death, in certain cases, as required by the Sanitary Code of Texas; and the further fact that, as a safeguard in the detection and prevention of crime, dead bodies should not be cremated until the cause of death is determined; the importance of this legislation to the public health, vital statistics, and public safety of the people of Texas, constitute an emergency and an imperative public necessity that the constitutional rule requiring bills to be read on three several days in each House, be and the same is hereby suspended, and it is enacted that this Act shall take effect and be in force from and after its passage.

VENEREAL DISEASE IN U. S. TROOPS

Figures released by the War Department indicate that 1 out of every 500 members of the U. S. Army throughout the world were admitted to hospitals for treatment of venereal disease during the average week in July, 1946. The rate in the United States was 1 out of 1,000; in the European Theater, 1 out of 200; in the Western Pacific area, 1 out of 333.

TROPICAL MEDICINE INSTITUTE FOR LIBERIA

Establishment in Liberia of an Institute for Research in Tropical Medicine for the development of effective methods of disease control and eradication was revealed recently at a dinner commemorating the one hundredth anniversary of the independence of the Republic of Liberia. The institute will be operated by the American Foundation for Tropical Medicine, but construction of the necessary building has been assured through a gift of $250,000 from Harvey S. Firestone, Jr., president of the Firestone Tire and Rubber Company.

ARMY MEDICAL LIBRARY PLANS PUSHED

The Association of Honorary Consultants to the Army Medical Library, meeting in Washington on October 4-5, discussed plans for a new building to house the 110 year old library now operating in a non-fireproof structure built in 1887. Major General Norman T. Kirk, Surgeon General of the Army, reported that it was planned to ask Congress at the next session for enabling legislation to erect the new $10,000,000 library building and that it is hoped to include the request for funds in the 1948 budget.

Chauncey D. Leake, Ph. D., vice-president and dean of the University of Texas Medical Branch, Galveston, and one of the library consultants, spoke at the meeting regarding regional representatives for the Association.

Members of leading medical publishing houses met with the director of the library to discuss the difficulties encountered through microfilm copying. It was agreed that a code should be drawn up for the mutual benefit of libraries and publishers and for the protection of authors' copyright interests.

LIBRARY NOTES

PACKAGE SERVICE

The package library consists of collections of reprints and other periodical material on various subjects, prepared for lending to members of the Association. Requests for packages should be addressed "Library, State Medical Association of Texas, 1404 W. El Paso Street, Fort Worth 3, Texas." Twenty-five cents in stamps should be enclosed with the request to cover postage and part of the expense of collecting the material. Only one package may be borrowed at a time, and packages are allowed to remain in the hands of the borrower for 14 days.

Packages were mailed from the Library of the State Medical Association to the following during November:

Drs. Lamm and Lamm, La Feria—*Cesarean Section, technic* (11 articles).

Dr. E. T. Crim, Greenville—(1 journal).

Dr. R. L. Johnson, Pittsburg—*Children, hygiene and health* (12 articles).

Dr. Melvin R. Wilcox, Tyler—*Pneumonia* (18 articles).

Dr. W. R. Swanson, Taylor—*Blood Transfusion, plasma and serum* (19 articles).

Dr. O. Garcia, McAllen—*Mononucleosis, infectious* (13 articles).

Dr. R. E. Lovett, Olney—*Migraine* (17 articles); *Pruritus, ani* (11 articles).

Dr. J. J. Hopkins, Bryan—*Hodgkin's Disease* (15 articles).

Dr. Thomas E. Cook, Dallas—*Hepatitis* (17 articles).

Dr. H. Jaworski, Waco—*War, medicine* (14 articles).

Dr. R. B. Grammer, Fort Worth—*Colitis* (7 articles); *Arteries, coronary* (6 articles).

Dr. David M. Marclay, Amarillo—*Digitalis, toxicty* (10 articles).

Dr. Stewart Cooper, Abilene—*Asthma* (20 articles); *Asthma, therapy* (13 articles); (2 journals).

Dr. J. P. McAnulty, San Angelo—*Bones, marrow* (10 articles).

Dr. John D. Gleckler, Denison—(2 journals).

Southwestern Medical College, Library, Dallas—(1 journal).

Dr. J. D. Casey, San Benito—(1 journal).

Dr. Erle D. Sellers, Abilene—*Extremities, blood supply* (1 articles).

Dr. Joe A. Shepperd, Burnet—*Impregnation* (12 articles).

Dr. C. D. Strother, Sherman—*Penicillin* (22 articles).

Dr. Oscar Huff, Pampa—*Sterility, therapy* (8 articles).

Dr. R. H. McCarty, Lubbock—*Liver, cirrhosis* (16 articles).

Dr. James C. Strong, Paris—*Anesthesia, pentothal sodium* (12 articles).

Dr. F. M. Rogers, Austin—*Cardiovascular System, roentgenography* (7 articles).

Dr. S. H. Watson, Waxahachie—*Myasthenia, gravis* (19 articles).

Mr. Henry Herren, La Feria—*Tuberculosis, epidemiology and statistics* (8 articles).

Dr. George M. Tulloch, Okmulgee, Okla.—24 journals).

Dr. L. B. Outlar, Wharton—*Undulant Fever* (17 articles).

Dr. Thomas W. Kemper, Marshall—*Pituitary Body, pathology* (8 articles).

Dr. W. H. Williams, Abilene—*Embolism* (12 articles); *Heparin* (7 articles).

Dr. S. E. Thompson, Kerrville—*Arteriosclerosis* (19 articles); *Pancreas, diseases* (14 articles); *Arteriosclerosis, cerebral* (10 articles).

Dr. F. A. White, Childress—*Glaucoma* (20 articles).

Dr. Harold M. Northington, Wharton—*Guillain-Barre Syndrome* (6 articles).

Dr. Earl R. Cockerell, Abilene—(1 journal).

Dr. M. D. Watkins, Lubbock—*Anesthesia* (4 articles).

Dr. C. J. Koerth, Kerrville—*Pneumoperitoneum* (14 articles).

Dr. Charles Mims, Mission—*Brain, hemorrhage* (7 articles).

Mrs. T. S. Edwards, Knox City—*Public Health* (13 articles).

Dr. R. E. L. Mewshaw, Waco—*Plague* (7 articles); *Tularemia* (31 articles).

Dr. T. D. Young, Roscoe—(1 journal).

King's Daughters Hospital Library, Temple—*Rabies* (21 articles).

Dr. James W. Williams, Mineola—*Migraine, therapy* (9 articles).

Dr. M. W. Caskey, Wichita Falls—*Epilepsy* (14 articles).

Dr. J. M. Estes, Jr., Abilene—*Impregnation, artificial* (9 articles).

Dr. E. H. Strauss, Big Spring—*Anesthesia, saddle block* (1 article).

Dr. Gordon F. Madding, San Angelo—*Nursing* (8 articles).

Mr. Ralph W. Yarborough, Austin—*Heat, stroke* (15 articles).

Dr. W. A. Chernosky, Temple—(1 journal).

Dr. Charles K. Bivings, Albuquerque, N. M.—*Rectum and Colon, cancer* (3 articles).

Dr. Louis W. Breck, El Paso—*Bones* (18 articles); (1 journal).

Dr. J. W. Gooch, Shamrock—*Eclampsia* (4 articles).

Dr. William Hibbitts, Texarkana—*Uterus, excision* (27 articles).

Dr. R. C. Stokes, Fort Worth—(1 journal).

Dr. C. E. Adams, Abilene—*Paralysis, spastic* (18 articles).

Dr. A. C. Cory, Farmersville—(1 journal).

Packages on compulsory sickness insurance to superintendents, debate coaches, and students in Texas high schools, 56.

ACCESSIONS

New York, Harcourt, Brace & Co.—Williams: The Human Frontier.

Chicago, Year Book Publishing Company—Brunner: Intracranial Complications of Ear, Nose and Throat Infections; Schiff: The Differential Diagnosis of Jaundice.

SUMMARY

REPRINTS RECEIVED, 1,158.	LOCAL USERS, 48.
JOURNALS RECEIVED, 207.	BORROWERS BY MAIL, 55.
ITEMS CONSULTED, 183.	PACKAGES MAILED, 63.
ITEMS TAKEN OUT, 132.	ITEMS MAILED, 697.

TOTAL ITEMS CONSULTED AND MAILED, 965.

MOTION PICTURE FILM LIBRARY

Motion picture films on medical subjects, 16 mm., both silent and sound, some in color, and suitable for either medical or lay audiences, are available for loan to county medical societies, hospital staffs, or individual physicians, on request. Borrowers will be required to pay only the cost of shipment of the films, by express, with insurance, and for any damage to films while in the hands of the borrower.

Requests for films should be addressed to "Motion Picture Film Library, State Medical Association of Texas, 1404 West El Paso Street, Fort Worth 3, Texas." A list of available films, with descriptions, will be furnished on request.

The following motion picture films were loaned by the Film Library of the State Medical Association of Texas during November:

Antitoxins, Globulin Modified (Available through the courtesy of Lederle Laboratories, Inc.)—Harris School of Nursing, Fort Worth.

Behind the Shadows (Available through the courtesy of the Texas Tuberculosis Association)—Tuberculosis Association, Southeastern District Medical Society, Lufkin.

D. D. T., the Story of (Available through the courtesy of British Information Services)—Premedical and educational students, Lamar College, Beaumont, and St. Paul's Hospital School of Nursing, Dallas.

Eyes for Tomorrow (Available through the courtesy of the Hurst Eye, Ear, Nose, and Throat Hospital-Clinic, Longview)—St. Paul's Hospital School of Nursing, Dallas, and Gregg County Medical Society, Longview.

From Moo to You (Available through the courtesy of the Borden Company)—Coöperative Extension Service, Clinton Avenue Junior High School, Lake Como Junior High School, and the Butler Housing Project, Fort Worth.

Golden Glory (Available through the courtesy of Standard Brands, Inc.)—Public Health Nursing Division, City Hall, Fort Worth.

Goodbye, Mr. Germ (Available through the courtesy of the Texas Tuberculosis Association)—Tuberculosis Association, Southeastern District Medical Society, Lufkin.

Hidden Hunger (Available through the courtesy of Swift & Co.)—St. Paul's Hospital School of Nursing, Dallas.

Know for Sure (Available through the courtesy of the Texas State Board of Health)—Health Department, Sanitation Schools, Foodhandlers' Classes, Fort Worth.

Magic Bullets (Available through the courtesy of the U. S. Public Health Service)—Harris School of Nursing, Fort Worth.

Poliomyelitis, Sister Kenny Method of Treatment of (Available through the courtesy of Dr. Herbert E. Hipps, Waco)—St. Paul's Hospital School of Nursing, Dallas.

Sulfonamide Therapy (Available through the courtesy of Lederle Laboratories, Inc.)—Lamar College, Beaumont.

Tuberculosis, Diagnostic Procedure in (Available through the courtesy of the Texas Tuberculosis Association)—Gregg County Medical Society, Longview.

Vitamins and Some Deficiency Diseases (Available through the courtesy of Lederle Laboratories, Inc.)—Lamar College, Beaumont.

When Bobby Goes to School (Available through the courtesy of Mead Johnson & Company)—Lamar College, Beaumont.

NEW MOTION PICTURE FOR THE FILM LIBRARY

The Motion Picture Film Library of the State Medical Association has received from Abbott Laboratories, North Chicago, Ill., the following film, which is now available for loan on request.

Intravenous Anesthesia. 16 mm., silent, showing time, 42 minutes. This film was produced by Mervin W. La Rue at Walter Reed Hospital, Washington, D. C., and the Percy Jones General Hospital, Battle Creek, Mich., in 1945-1946. It is a teaching film prepared to illustrate the simplest technique for the cautious clinical administration of the drug as well as the careful and most important management of the patient during anesthesia. Considerable footage is allowed to various surgical procedures being performed under intravenous anesthesia.

The physician showing the film should call attention to the fact that idiosyncrasy or overdosage may be encountered, and treatment of such conditions should be given. Also the proved value of combining the inhalation of equal parts of nitrous oxide and oxygen with intravenous pentothal should be stressed. Two typographical errors in the text need correcting.

This film is recommended for the teaching of medical students, anesthesiology residents, and any physicians who need instruction in the proper administration of intravenous pentothal anesthesia.

BOOK NOTES

POSTGRADUATE MEDICINE BEGINS PUBLICATION

The Interstate Postgraduate Medical Association of North America in January, 1947, will launch a new monthly journal, *Postgraduate Medicine*, the association announces. As the official publication of the organization, the journal will draw on the papers and diagnostic clinics of the annual meetings of the association for its pages, but supplemental material from other postgraduate sources will be included. The new publication will supplant the single volume which has previously made available the papers and clinics of each annual meeting of the Association. Scientific and clinical articles on general medicine with emphasis on treatment will be featured, but there will be departments devoted to a review of medical events and meetings, clinical photography, consultation service, book reviews, new drugs and instruments.

[1]Diseases of the Retina. By Herman Elwyn, M. D., Senior Assistant Surgeon, New York Eye and Ear Infirmary. Cloth, 587 pages, with 170 illustrations, 19 in color. Price, $10.00. Philadelphia and Toronto, The Blakiston Company, 1946.

This book is divided into eight parts: diseases of the retina resulting from disturbances in circulation; diseases of the retina resulting from vascular formations; degenerative diseases of the retina on a hereditary basis; inflammatory diseases of the retina; tumors of the retina; diseases of the retina leading to retinal detachment; developmental anomalies of the retina; and radiation injuries of the retina.

The author has omitted some of the references to earlier writers mentioned in the voluminous textbooks of ophthalmology, makes frequent reference to the recent literature on the subject, and has written the book in a narrative style so that it is interesting reading. It is worthy of examination by every ophthalmologist.

[2]Diabetes. A Concise Presentation. By Henry J. John, M. A., M. D., F. A. C. P., Lt. Col., M. C. Cloth, 300 pages. Price, $3.25. St. Louis, The C. V. Mosby Company, 1946.

In his preface, Colonel John gives the *raison d'etre* of his book as follows: "The need for such a book was impressed upon me by my contact with medical men in the Army during World War II. Many of these medical officers, well trained in modern medicine, showed theoretical knowledge of diabetes but seemed to lack experience in the practical application of this knowledge."

The author, already a wide writer in the field of diabetes, has presented concisely, yet without omissions, a treatise on diabetes which could be used to great advantage by those physicians who are called upon suddenly to treat cases of diabetes and who need a rapid, practical, and authoritative review of the subject. The volume would appeal to medical officers in the Armed Services, to members of resi-

[1]Reviewed by John W. Eschenbrenner, M. D., Fort Worth.
[2]Reviewed by John K. Glen, M. D., Houston.

dent staffs of hospitals, and to general practitioners of medicine who are called upon at rare intervals to treat cases of diabetes.

No claim is made by the author that the material presented is in any way new. In fact, he expresses thanks to many publishers who granted him the privilege of reproducing much of the text from papers previously published.

The book comprises eighteen chapters and a list of references. Proper emphasis is placed upon diagnosis and upon the differential diagnosis of glycosuria with illustrative case reports. The discussion of treatment spans from the author's long experience in the treatment of diabetes and is written from a strictly clinical viewpoint. There are chapters upon the care of diabetic patients who have such complications as pregnancy, hyperthyroidism, and surgical emergencies, and there is an excellent, though not exhaustive, discussion of diabetes in children. There is an important chapter on "Do's and Don'ts." The chapter on diet is not exhaustive but is entirely adequate to the purpose of the book.

[3]**Textbook of Obstetrics.** By Henricus J. Stander, M. D., F. A. C. S., Professor of Obstetrics and Gynecology, Cornell University Medical College; Obstetrician and Gynecologist-in-Chief, New York Hospital and Director of the Lying-In Hospital, New York City. Cloth, 1,277 pages and 740 illustrations. Price, $10.00. New York and London, D. Appleton-Century Co., Inc., 1945.

This volume represents the ninth edition of the original "Williams' Obstetrics," the third revision by Stander. The title of the text has been changed from "Williams' Obstetrics" to "Textbook of Obstetrics," by Stander. This change may come as a surprise to some, but Dr. Stander states that he feels he should shoulder full responsibility for the statements made, as they represent his own methods of practice and teaching. However, many of the excellent illustrations and descriptions from Williams have been retained in the new book. The illustrations used in describing various episiotomy repair techniques are among the worth-while additions.

Although the plan of presentation is similar to that of the last edition of "Williams' Obstetrics," there is much new material in this latest text. Some sections have been completely revised and brought up to date. Much thought has been given to the condensation of the voluminous literature concerning the toxemias of pregnancy. The sections devoted to abnormal pelves are reorganized and more recent data comprehensively described. X-ray pelvimetry is understandably edited. A timely discussion of the new drugs and techniques, in particular a review of the uses of demerol, and apt comments on caudal anesthesia have been added to the section on analgesia and anesthesia.

A comprehensive review and discussion of the Rh factor in relation to obstetrics is covered in the section "Diseases and Abnormalities of the Newborn Child."

The historical data and a great deal of the detailed technical material are presented in small type, while the practical material is in larger type. This will aid the student considerably and make for quick and easy reference for the practitioner and specialist.

"The Textbook of Obstetrics," like the former "Williams' Obstetrics," is one of the definitive texts on the subject.

[4]**Anesthesia in General Practice.** By Stuart C. Cullen, M. D., Head of Division of Anesthesiology, Department of Surgery, State University of Iowa Hospitals; Associate Professor of Surgery (Anesthesiology), State University of Iowa College of Medicine. Cloth, 260 pages. Price, $3.50. Chicago, The Year Book Publishers, Inc., 1946.

It is a pleasure to review a book written by such an outstanding author whom I have had the pleasure to know and to find that another valuable book is added to literature on anesthesia. While it is primarily to be used as a text for medical students and residents, physicians in practice who know something of anesthesia will find it a valuable guide and brief reference. The chapter on premedication is well written and contains a fine chart on premedication dosage for various anesthesia agents.

Another chart that is worth mentioning is one on drugs commonly used for nerve block and spinal analgesia. The cartoons are unusual. They carry a picture message that is very impressive. Although some of the special techniques such as intubation, continuous spinal anesthesia, and curare are mentioned in brief form, the author states that the text is not intended as a complete work on anesthesia. The chapter on curare is interesting; the author has written a great deal on this subject and has probably done as much work as any person in this country on this drug. The appearance of such books on anesthesia and the inclusion of anesthesiology in the curriculum of the medical school is a sign of progress in anesthesia and surgery.

[5]**Diseases of the Adrenals.** By Louis J. Soffer, M. D., Adjunct Attending Physician, The Mount Sinai Hospital, New York City. Cloth, 304 pages. Illustrated with 42 Engravings and 2 Colored Plates. Price, $5.50. Philadelphia, Lea & Febiger, 1946.

In this most recent monograph on diseases of the adrenal glands, Dr. Soffer has included much new material not to be found in earlier, although perhaps more comprehensive, treatises. The book is not as lengthy as some of the earlier works on the subject, notably that of Goldheizer, and may be thought of as a modern handbook of diagnosis and treatment.

The anatomy and histology is disposed of in six pages, but considerable more attention is paid to physiology. Chapter II is devoted to an exhaustive account of the assay of the urinary 17-ketosteroids. In evaluation of the 17-ketosteroids, excretion in the urine is discussed with reference to various normal and pathologic states. Dr. Soffer emphasizes the importance of this adjunct to diagnosis in conditions such as carcinoma of the adrenal in which ketosteroid values are exceptionally high and in other conditions, such as cortical hyperplasia, in which they are not so strikingly elevated. Considerable attention is paid to the subject of Addison's disease, especially with reference to modern treatment both of the crisis and intercritical period. A comprehensive evaluation of the use of desoxycorticosterone is given.

The technique of perirenal insufflation is discussed in some detail and also the dangers of this technique.

In discussing the Waterhouse-Friderichsen syndrome, Dr. Soffer makes the point that death is apparently caused by the overwhelming sepsis rather than bilateral adrenal hemorrhage, since it is doubtful that acute adrenal insufficiency can develop in such a short period of time.

Dr. Soffer's discussion of the adrenogenital syndrome and Cushing's syndrome are fairly good but present no new material for consideration.

Dr. Soffer's presentation of adrenal tumors attempts to correlate the pathologic picture with the clinical finding and the differential diagnoses are discussed. His classification of adrenal tumors is, however, somewhat confusing and perhaps need-

[3]Reviewed by Walter S. Morse, M. D., Houston.
[4]Reviewed by R. A. Miller, M. D., San Antonio.
[5]Reviewed by H. W. Neidhardt, M. D., Department of Pathology, University of Texas Medical Branch, Galveston.

lessly complicated. The same may be said of other treatises on this very difficult subject. Most of the confusion is the result of failure to use a standardized nomenclature.

On the whole, the book seems to contain a great deal of valuable and up-to-date information and probably will be quite interesting to the practicing internist. A vast amount of current literature has been condensed into this well organized book.

NEWS

Contributions to this department will be appreciated. News should be of general medical interest, such as public health activities, new hospitals, personal items of more than local value, etc. News for a particular number of the JOURNAL should be in the hands of the Editor not later than the fifteenth of the preceding month.

Army Medical Department Civilian Consultants have been increased by another 122 experts, the office of the Surgeon General has announced. Among those named in October are the following Texans: Drs. William W. Bondurant, Jr., San Antonio, and Henry M. Winans, Dallas, internal medicine; Drs. Titus H. Harris, Martin L. Towler, and Hamilton F. Ford, all of Galveston, and Melvin W. Thorner, San Antonio, neuropsychiatry; Dr. Jack R. Ewalt, Galveston, psychiatry; and Dr. James W. Bass, Dallas, history of preventive medicine, Southwest Pacific Area.

The American Urological Association has announced its annual award "not to exceed $500" for an essay on the result of clinical or laboratory research in urology by a urologist who has not been in that special practice for more than five years or a resident in urology in a recognized hospital. Essays must be submitted before May 1, 1947, to Dr. Thomas D. Moore, Secretary, 899 Madison Avenue, Memphis, Tenn., from whom additional information is available.

New Clinics have been planned for Rosenberg and San Antonio, newspaper accounts announce. Dr. J. W. Weeks, Rosenberg, proposes to erect within the next few months a clinic building to accommodate five physicians, informs the Rosenberg *Herald*. The building will be erected adjoining the Fort Bend Hospital. Construction of a $45,500 brick clinic building in San Antonio has been approved by the Civilian Production Administration, states the San Antonio *News*. Drs. S. Foster Moore, E. T. Coates, and Frank M. Martin will build the clinic.

The East Texas Medical Service Society, meeting in Tyler on October 26, heard a report on the East Texas Physio-Therapy Center established by the society, reports the Tyler *Courier-Times-Telegraph*. In less than three months of operation, 44 patients have been undergoing treatment three times a week and only 1 patient has failed to respond to treatment. The National Foundation for Infantile Paralysis is coöperating both financially and with encouragement. Principal speaker for the luncheon meeting was Dr. Oscar B. Marchman, Dallas, and thirty members of the Dallas chapter of the medical service society were guests.

The Veterans Administration Need for Physicians and nurses to staff hospitals in the Southwest and also in the out-patient service has been recently urged by Dr. Lee D. Cady, Dallas Branch medical director for the administration. The McKinney *Courier-Gazette* recently quoted Dr. Cady as pointing to the 42 per cent increase in patients at the eleven Dallas Branch hospitals since V-J Day and the national increase of 29 per cent in the number of hospitalized patients to indicate the increasing demand for qualified personnel if veterans are to receive the superior care to which they are entitled. Dr. Cady also reported that the number of World War II Veterans receiving medical care for service connected disabilities has increased 70 per cent and for nonservice connected disabilities, 117 per cent. The hospitals now operated in this area by the Veterans Administration, all of which are teaching units, will be increased by nine new hospitals to be built during the next two and one-half years. Physicians, nurses, social workers, and technicians who desire additional information concerning the opportunities for employment may contact the Director of Personnel, Veterans Administration Branch Office No. 10, 1114 Commerce Street, Dallas.

Naval Reserve Medical Officers are desired for participation in the Naval Air Reserve Training program, according to an appeal from the Training Command at Glenview, Ill. Naval flight surgeons may affiliate themselves with either the organized or volunteer components of the Inactive Reserve which entails part-time shore duty with a Naval Air Station or Naval Air Reserve Training Station. Personnel in the ranks of commander and lieutenant commander in the Medical Corps are particularly needed for full-time active duty with the Naval Reserve, and officers are assured of consideration in obtaining and continuing duty at the station of their preference. Further information may be obtained from the Bureau of Naval Personnel, via the Chief of Naval Air Reserve Training, Naval Air Station, Glenview, Ill.

Southwestern Medical College.—Two members of the Southwestern Medical College staff have been commended by the University of Guadalajara (Mexico) for their assistance in reorganizing its school of medicine, reports the Dallas *News*. Dr. Arthur Grollman and the late Dr. A. I. Folsom assisted in arranging a curriculum for the Mexican university based to some degree on that in effect at Southwestern. It is understood that the Guadalajara institution contemplates naming its department of urology in memory of Dr. Folsom.

University of Texas.—A postgraduate course in surgery was held at the University of Texas School of Medicine, Galveston, November 18-23, with the primary intention of reviewing recent developments in the field. The Galveston *Tribune* indicates that the program was conducted almost entirely by staff members of the school, including Drs. Robert M. Moore, Charles A. Hooks, A. O. Singleton, Edgar J. Poth, J. M. Thiel, and J. P. McNeill, surgery; W. W. Glass, Jr., William H. Ainsworth, G. W. N. Eggers, orthopedic surgery; Robert E. Cone, Graham McDonald Coffman, and W. L. Bush, urology; Truman G. Blocker, Jr., plastic and maxillofacial surgery; A. W. Harrison, chest surgery; S. R. Snodgrass, neurosurgery; Robert I. Wise, bacteriology; J. K. Lamar, obstetrics and gynecology; M. Brucer, physiology; and H. C. Slocum, anesthesiology.

Forty graduates of the John Sealy College of Nursing were awarded diplomas November 1, reports the Galveston *Tribune*. Miss Helen Frances Ziegler, dean of the school of nursing at Vanderbilt University, delivered the commencement address.

Dr. Truman G. Blocker, Jr., professor of maxillofacial surgery, has been appointed director of the postgraduate training program of the University of Texas School of Medicine to succeed Dr. George M. Decherd, who has become director of health services at the Main Branch in Austin, according to the Galveston *News*.

Chauncey D. Leake, Ph. D., vice-president and dean of the University of Texas Medical Branch, was the principal speaker when the Riverside County Medical Society of Southern California held a special dinner in Palm Springs, Calif., on November 9 to commemorate the centennial of ether anesthesia.

Dr. Eric Ogden, professor of physiology at the University of Texas Medical Branch, gave a series of lectures on the cardiovascular system at New York University College of Medicine during November, the college informs.

Dr. Arild Hansen, professor of pediatrics and chairman of the Child Health Program of the University of Texas Medical Branch, during November attended the American Council of Rheumatic Fever convention in New York, a meeting of the editorial board of the *Journal of Pediatrics* and the American Academy of Pediatrics in Pittsburgh, Pa., and a meeting of the scientific committee of the national livestock and meat board in Chicago, according to the Galveston *Tribune*.

Dr. Edgar J. Poth, professor of surgery, and Dr. John McGivney, instructor in surgery at the University of Texas Medical Branch, presented papers at the Southern Medical Association meeting in Miami, Fla., November 4-7.

A. Packchanian, Ph. D., associate professor of bacteriology at the University of Texas Medical Branch, attended the first Inter-American Congress of Medicine in Rio de Janeiro, Brazil, in September, according to *The Journal of the American Medical Association*. Two Rio de Janeiro physicians, Drs. Emmanuel Dias and F. Laranja, have been visitors at the University of Texas and are conducting field trips in Texas to study cases of Chagas' disease in coöperation with Dr. Packchanian.

Personals

Dr. and Mrs. A. O. Scarborough, Mineral Wells, observed their sixtieth wedding anniversary October 26 with a family dinner given by their daughter, informs the Abilene *Reporter-News*. Close friends called during the afternoon. Dr. Scarborough retired three years ago from practice in Snyder, where he had been active for many years.

Dr. I. C. Morris, who came to Borger in 1926 during the oil boom, has retired after almost forty-five years of practice, reports the Borger *Herald*. Dr. Morris has returned to his native state of Arkansas to a farm at Rogers.

Dr. Cecil O. Patterson, Dallas, was named chairman of the Section on Gastroenterology of the Southern Medical Association at its meeting in Miami, Fla., November 4-7. He has served as secretary of the section for the past two years, according to the Dallas *Times Herald*. An exhibit on a new treatment for bleeding of the esophagus prepared by Dr. Patterson was awarded honorable mention at the meeting.

Dr. Erich Spier and *Dr. T. J. B. Shanley*, El Paso, became fellows in the International College of Surgeons at a recent assembly of the United States chapter in Detroit, states the El Paso *Times*.

Dr. William F. Mengert, Dallas, was recently named president-elect of the Central Association of Obstetricians and Gynecologists, informs *The Journal of the American Medical Association*.

Dr. Rollin S. Fillmore, formerly of Jacksboro and a veteran of World Wars I and II, will be the chief medical officer of a newly established medical division of the Veterans Administration sub-regional office in Amarillo, announces the Amarillo *Times*.

Dr. Gaylord A. Hart, Dallas, presented a paper on the relationship of the general practitioner and the surgeon for the Southern Medical Association in Miami, Fla., early in November, according to *The Journal of the American Medical Association*.

Dr. George R. Hodell, Houston, has passed the oral and written examinations for fellowship in the American College of Chest Physicians, the college announces.

Marriages

Dr. William Riley Snow, Abilene, married Mrs. William Emmett Ryan in Amarillo on September 1.

Births

To *Dr. and Mrs. H. A. Tubbs*, Fredericksburg, a daughter, Betty Jo.

To *Dr. and Mrs. E. L. Dyer*, Kerrville, a daughter, Alice Ruth, on July 28.

To *Dr. and Mrs. David McCullough*, Kerrville, a son, David, Jr., on September 28.

SOCIETY NEWS

Austin County Society

October 8, 1946

Dr. and Mrs. F. W. Hover, Sealy, were hosts to Austin County Medical Society and Auxiliary for dinner October 8. Fourteen guests were present. Meetings of each group were held following the meal.

Colorado-Fayette Counties Society

October 22, 1946

(Reported by C. I. Shult, Secretary)

Treatment of Congestive Heart Disease with High Fluid Intake —Merton M. Minter, San Antonio.

Merton M. Minter, San Antonio, was guest speaker for Colorado-Fayette Counties Medical Society when it met in Schulenburg on October 22. L. J. Peters, Schulenburg, president, presided over the session, which was preceded by a dinner at which the auxiliary was also present. Several cases were reported and a general discussion followed the paper on congestive heart disease.

Hidalgo-Starr Counties Society

October 10, 1946

Report on the Wagner-Murray-Dingell Bill—Foy Moody, Corpus Christi, and Ernest Miller, Beeville.

Auxiliary members joined members of the Hidalgo-Starr Counties Medical Society for a meeting October 10 in Mission at which the Wagner-Murray-Dingell bill was discussed by Foy Moody, Corpus Christi, and Ernest Miller, Beeville.

Hunt County Society

October 8, 1946

(Reported by Harriet Rogers, Secretary)

Newer Trends in Pediatrics—Lois Weir Smith, Dallas.

A practical discussion of new trends in pediatrics was presented by Lois Weir Smith, Dallas, guest speaker for Hunt County Medical Society on October 8. Dr. Smith emphasized that the time to prevent psychoses and insanity is in early infancy, and that each baby is entitled to a calm, quiet environment in which he is treated like a human being with individual personality reactions instead of like a clock. She encouraged the use of breast milk for at least two to four months and regular doses of cod liver oil for more than the first three or four months. She also urged the value of immunizations, especially against diphtheria, which has been predicted to reach epidemic stages this year. A general discussion centered primarily on the immunization problem was entered into by the eight members and two visitors present.

Ralph Jenks, Greenville, announced that a mobile x-ray unit for tuberculosis case finding would be in Greenville on November 25 and in Commerce the next day.

S. D. Whitten, Greenville, president, presided.

Jefferson County Society

October 14, 1946

(Reported by L. R. Byrd, Jr., Secretary)

Jefferson County Medical Society, meeting October 14 at St. Mary's Hospital, Port Arthur, passed a motion made by L. C. Powell, Beaumont, and seconded by Dan H. Byram, Port Arthur, endorsing the prepayment hospital and medical and surgical plans approved by the American Medical Association and the State Medical Association. The action fol-

lowed presentation of a historical survey of such prepaid plans and reading of recent reports on the subject by American Medical Association boards and councils by H. E. Alexander, Beaumont, member of the Economics Committee, and a discussion of the Blue Cross plan by Rex L. Tidwell, Houston regional director for Blue Cross. President George Sladczyk, Port Arthur, had proposed consideration of community chest coverage of certain low income groups for medical care, and promotion by the society of interest in group hospital and medical and surgical service plans among employers of large and small groups and leaders of civic organizations.

Upon motion of C. H. Todd, Beaumont, seconded by J. C. Crager, Beaumont, the society adopted an amendment to the By-Laws providing for employment of an executive secretary to assist the secretary-treasurer.

The Economics Committee, through Dr. Alexander, proposed an amendment to the By-Laws under which a seven member adjudication committee "to supervise industrial compensation practice and disputed bills in industrial and private practice" would be elected at the annual business meeting of the society.

I. G. Wilson, Beaumont, was accepted for membership upon transfer from Jasper-Newton Counties Medical Society.

A letter inviting society members to attend a dinner honoring Allen Shivers, lieutenant-governor elect of Texas, and Mrs. Shivers on October 17 was read.

Lamar County Society

November 7, 1946

Present Day Treatment of Venereal Diseases—Lamar A. Byers, Paris.

Twenty members of Lamar County Medical Society attended a dinner meeting November 7 at the Paris Golf Club. Lamar A. Byers, director of the Paris-Lamar County Health Unit, spoke on the treatment of venereal diseases.

Smith County Society

October 10, 1946

Histologic Anatomy of the Liver—J. W. Birdwell, Tyler.
Prothrombin and Vitamin K—Melvin Wilcox, Tyler.
Physiological Basis for Liver Function Tests—M. H. Moore, Tyler.

Twenty-six members were present for the first meeting this season of the Smith County Medical Society in the dining room of Mother Frances Hospital, Tyler, October 10. The scientific program outlined above was presented by Orion Thompson, Tyler, program committee chairman, who suggested that each member of the society prepare a paper to be used for society programs during the coming year and that societies in adjoining counties be offered these programs.

The society voted to appoint a committee to work with school officials in securing a mobile photofluoroscopic unit to make chest studies of high school sophomores and seniors.

B. N. Wilson, Tyler, was approved for membership by transfer from a Minnesota county society.

Tarrant County Society

November 5, 1946

(Reported by W. P. Higgins, Jr., Secretary)

Recent Advances in the Treatment of Appendicitis—Robert L. Sewell, Fort Worth.
The Treatment Program at the U. S. Public Health Service Hospital—W. F. Ossenfort, Officer in Charge, Fort Worth.

A resolution urging support by Tarrant County state legislators of bills providing for a basic science law and a revised medical practice law was adopted by Tarrant County Medical Society on November 5. Thirty-five members were present at the meeting in the Medical Arts Auditorium, Fort Worth. A letter from the State Medical Association regarding the bills was read by the secretary, and motion to pass the resolution was made by Hub E. Isaacks, Fort Worth, seconded by Frank G. Sanders, Fort Worth, following discussion by R. G. Baker and John J. Andujar, Fort Worth. Copies of the resolution and bills were to be sent to Tarrant County senators and representatives.

W. B. West, Fort Worth, vice-president, presided over the scientific program outlined above. R. J. White and Harold J. Shelley, Fort Worth, and John A. Hammack, Kennedale, discussed the paper by Robert L. Sewell, and Hub E. Isaacks, Fort Worth, discussed the paper by W. F. Ossenfort.

Frank S. Schoonover, Jr., brought three items to the attention of the society: (1) a suggestion that terms of trustees of the State Medical Association be limited to six years with a given trustee ineligible for reëlection for a similar period following his trusteeship; (2) the positive program of the American Association of Physicians and Surgeons toward proposed legislation concerned with socialized medicine; and (3) a suggestion that the name of the City-County Hospital be changed to Petersmith Hospital to avoid the stigma of charity for patients treated there.

A representative from the Metropolitan Casualty Insurance Company of New York presented that company's plan for group sickness and accident coverage.

Douglas E. Bibby, James O. McBride, Johnnie E. Monaghan, Jr., John L. Wallace, Jr., and Walter H. Stapp, all of Fort Worth, were elected to membership upon application.

A stag party for physicians to be given by the Renfro Drug Company on November 13 at the Casino was announced by M. H. Crabb, Fort Worth, chairman of the entertainment committee.

November 19, 1946

(Reported by W. P. Higgins, Jr., Secretary)

Our Tumor Clinic—Porter Brown, Fort Worth.
Carcinoma of the Colon with Complications—T. H. Thomason, Fort Worth.
X-Ray Diagnosis of Carcinoma of the Stomach—R. P. O'Bannon, Fort Worth.

Fifty members and two visitors heard about a new tumor clinic being established at the City-County Hospital, Fort Worth, to serve the entire northwest Texas area when Tarrant County Medical Society met in the Medical Arts Auditorium, Fort Worth, November 19. Porter Brown, in discussing the tumor clinic, said that 100 milligrams of radium have been purchased for use at the clinic.

T. H. Thomason, Fort Worth, urged that physicians be constantly alert for the first manifestations of cancer. He stated that of all gastro-intestinal malignancy, approximately 50 per cent involves the large intestine, and about 20 per cent of these malignancies are in the sigmoid. George R. Enloe, R. J. White, B. C. Ball, W. C. Tatum, Harold M. Williams, M. C. Archer, Oscar W. Haffke, John J. Andujar, and Dr. Brown discussed Dr. Thomason's presentation.

R. P. O'Bannon discussed x-ray diagnosis of carcinoma of the stomach, presenting case reports illustrated by slides.

Arthur J. Auringer, Arlington, and Robert G. Lemon, Leo N. Roan, and Marie L. Shaw, Fort Worth, were elected to membership, Dr. Auringer by application and the others by transfer.

The secretary read a letter from the State Medical Association stating that the fiscal year of the association is being changed and asking for prompt payment of dues.

Tom Green-Eight County Society

October 7, 1946

Neurological Aspects of Congenital Defects in the Newborn—L. M. Helfer, San Antonio.

L. M. Helfer, San Antonio, was guest speaker for Tom Green-Eight County Medical Society on October

7. He discussed neurological aspects of congenital defects in the newborn.

Announcement was made of the district society meeting in Brady to be held October 23.

Eleventh District Society

October 24, 1946

(Reported by C. B. Young, Secretary)

Diverticulitis and Diverticulosis—J. T. Boyd, Jacksonville.
Discussion—Fred E. Felder, Palestine.
Urological Anomalies—Max Moulder, Longview.
Discussion—Thomas M. Jarmon, Tyler.
Luncheon: Responsibility of the Doctor to the Public—B. E. Pickett, Carrizo Springs, President-Elect, State Medical Association.
Diarrhea in Infants and Children—Masters H. Moore, Tyler.
Discussion—Orion Thompson, Tyler.
Wire Sutures and Early Ambulation in Surgery—Robert Bell, Palestine.
Discussion—E. H. Caldwell, Tyler.
Treatment of Diabetes Mellitus—James A. Greene, Houston.
Discussion—J. Weldon Birdwell, Tyler.
Prevention of Sudden Death in Obstetrics—Herman Johnson, Houston.
Discussion—C. E. Willingham, Tyler.

Approximately seventy-five physicians and their wives attended the fall meeting of Eleventh District Medical Society and Auxiliary at the Palestine Country Club, October 24. The two groups met jointly for luncheon, at which the President-Elect of the State Medical Association, B. E. Pickett, Carrizo Springs, spoke. The medical society heard the scientific program outlined above and a short talk by Congressman Tom Pickett, Crockett, in which he expressed unqualified opposition to the Wagner-Murray-Dingell bill.

Dues were set at $2 annually, and it was decided that membership cards would be issued.

Thirteenth District Society

October 24, 1946

(Reported by Joe R. Wise, Secretary)

The Persistent Positive Friedman Test in Hydatid Mole—May Owen, Fort Worth.
Cancer of the Colon—R. G. Baker, Fort Worth.
Present Status of Cancer—W. V. Ramsey, Abilene.
Luncheon: Address—C. C. Cody, Jr., Houston, President, State Medical Association.
Painful Conditions About the Shoulder—E. L. Graham, Cisco.
Modern Concept of Fractures of the Hand—Jack E. Maxfield, Wichita Falls.
Treatment of Varicose Veins and Ulcers—Harold J. Shelley, Fort Worth.
Rheumatic Fever and Some of Its Problems—R. E. L. Gowan, Graham.

Thirteenth District Medical Society met in Graham on October 24 for the program outlined above. The sixty-three members present decided that the next meeting would be held next spring at Abilene, and elected the following new officers: Frank Hodges, Abilene, president; V. L. Powers, Wichita Falls, vice-president; and Robert Stokes, Fort Worth, secretary-treasurer.

Fifteenth District Society

October 8, 1946

Invocation—Rev. W. C. Cummings, First Presbyterian Church, Marshall.
Welcome—S. W. Tenney, Marshall.
Anesthetics—Madison Ragland, Gilmer.
G. I. Disorders—Tate Miller, Dallas.
Common Skin Diseases—Everett Fox, Dallas.
Luncheon.
Address of President, State Medical Association—C. C. Cody, Jr., Houston.
Remarks of Secretary, State Medical Association—Holman Taylor, Fort Worth.
Report of Councilor—Charles A. Smith, Texarkana.
Business Meeting.
Meningococcemia with Pericarditis—Robert M. Barton, Dallas.
Pediatrics—J. Wirt Burnett, Texarkana.
Office Surgery—R. G. Granberry, Marshall.

Fifteenth District Medical Society met at Fern Lake near Marshall on October 9 with F. S. Littlejohn, Marshall, president, presiding. The program indicated above was carried out. During the business session, officers for the coming year were elected as follows: Joe Roberts, Longview, president; W. S. Terry, Jefferson, vice-president; and S. W. Tenney, Marshall, secretary-treasurer. Joe D. Nichols, Atlanta, was nominated as Councilor for the district, the nomination to be acted upon at the annual session of the State Medical Association in May, 1947.

AUXILIARY NOTES

Officers of the Woman's Auxiliary to the State Medical Association of Texas: President, Mrs. George Turner, El Paso; President-Elect, Mrs. Edward C. Ferguson, Beaumont; First Vice-President, Mrs. L. B. Windham, Tyler; Second Vice-President, Mrs. V. M. Longmire, Temple; Third Vice-President, Mrs. R. E. Clark, Memphis; Fourth Vice-President, Mrs. J. E. Hogan, Big Spring; Corresponding Secretary, Mrs. Robert F. Thompson, El Paso; Recording Secretary, Mrs. M. A. Ramsdell, San Antonio; Publicity Secretary, Mrs. J. F. Campbell, Fort Worth; Treasurer, Mrs. Guy Jones, Dallas; Parliamentarian, Mrs. Joe Nichols, Atlanta.

AUXILIARY NEWS

Bexar County Auxiliary honored Mrs. George Turner, El Paso, State Auxiliary president, with a luncheon at the San Antonio Country Club on October 11.

Ellis County Auxiliary held a luncheon at Waxahachie Country Club on November 9 with Mrs. George Turner, El Paso, State Auxiliary president, as honor guest and speaker. Mrs. Truman Terrell and her daughter, Miss Katherine Terrell, both of Fort Worth, and Mrs. Forrest Buchanan, Dallas, president of Dallas County Auxiliary, were other special guests. Mrs. S. H. Watson, president of the Ellis County Auxiliary and past president of the State Auxiliary, introduced Mrs. Turner. Mrs. Turner and Mrs. Buchanan were presented with corsages. Twenty-four women were present.

In the afternoon Mrs. S. P. Skinner entertained with a seated tea honoring the auxiliary guests and her house guest, Mrs. Frank Templeton, Ennis. Mrs. Turner presided at the tea service.

Galveston County Auxiliary entertained with an afternoon coffee at the Bayou Club, Galveston, on November 15. Mrs. M. L. Graves, Houston, spoke on the student loan fund, and Mrs. L. L. D. Tuttle, also of Houston, spoke briefly. Mah-jongg and bridge were played. Mrs. Hamilton Ford and Mrs. Clarence Sykes were in charge of arrangements, and Mrs. John L. Otto, presided. Arrangements of greenery decorated the rooms.—Mrs. John L. Otto, President.

Hopkins-Franklin Counties Auxiliary met September 18 in the home of the president, Mrs. L. Faulk, Sulphur Springs. Mrs. Earl Stirling, also of Sulphur Springs, was cohostess for this initial meeting of the year. Plans were discussed for the year's work. It was decided to have a "doctor's day" in October, to help local hospitals in securing student nurses, and to study new medicines. Refreshments were served to ten members. Fall flowers decorated the meeting rooms.—Mrs. W. Ray Hanna, Corresponding Secretary.

Jefferson County Auxiliary was entertained at a morning coffee in the Mirror Room of Hotel Beaumont, on October 3, with Mesdames P. Allison, H. E. Alexander, and J. A. Bybee, all of Beaumont, as hostesses. Mrs. Milton J. White, Port Arthur, presided in the absence of the president. Approximately sixty-five guests were served from a table decorated with chrysanthemums.—Mrs. G. R. Solis, Publicity Secretary.

Kerr-Kendall-Gillespie-Bandera Counties Auxiliary held its first meeting of the fall on October 13 at the home of Dr. and Mrs. S. E. Thompson, Kerrville. The medical society met with the auxiliary. Mrs. George Turner, El Paso, State Auxiliary president; Dr. M. M. Minter, San Antonio, chairman of

the Public Relations Committee of the State Medical Association; Dr. and Mrs. F. N. Haggard, San Antonio; and Dr. and Mrs. C. B. Alexander, San Antonio, were special guests introduced by Mrs. L. L. Keyser, Fredericksburg, president of the host auxiliary. Mrs. Turner told the group of the aims and purposes of the Auxiliary and suggested means of carrying on its work during the year. Dr. Minter, who was presented by Dr. W. E. Gregg, president of Kerr-Kendall-Gillespie-Bandera Counties Medical Society, discussed the proposed basic science bill and medical practice act bill. Dr. Gregg introduced new members of the society and welcomed several former members who have returned from military service. Following the meeting, supper was served by auxiliary members at the outdoor barbecue pit.—Mrs. W. E. Gregg, Acting Secretary.

McLennan County Auxiliary entertained Mrs. George Turner, El Paso, State Auxiliary president, at its October 17 meeting at the Waco Country Club. About fifty women were present. Mrs. Ray E. Bullard, president, presided, and Mesdames Boyd Alexander, W. A. Wood, M. C. Carlisle, W. E. Colgin, Ralph Coffelt, H. M. Anspach, M. D. Baker, and M. C. Barnes were hostesses. Mrs. Turner outlined the accomplishments she hopes the Auxiliary will achieve during 1946-1947, emphasizing the work of most importance to each county auxiliary. She stressed the idea of having members informed in health education who will pass along such information through personal contacts and other channels to laymen. The community chest was given $15, and new yearbooks were distributed.

A no-host dinner for Mrs. Turner, sponsored by Mesdames Bullard, Wood, H. R. Dudgeon, and F. F. Kirby, was held in the evening at a restaurant.—Mrs. F. F. Kirby, Publicity Chairman.

Nueces County Auxiliary has reported that a committee composed of Mesdames John Sloan (chairman), A. J. Ashmore, R. V. St. John, Edwin A. Danford, and C. Duncan Stewart, all of Corpus Christi, is at present leading the auxiliary in continuing a project begun in October, 1944: the organization and support of a blood donor system in Nueces County. Although the service makes available the names of professional donors, particular attention has been given to securing volunteer donors through churches, civic clubs, and other groups, so that blood will be available for patients unable to pay for it. Approximately two hundred names are on the list, which has been revised and typed for ready use. Drs. J. F. Pilcher and Y. C. Smith have assisted the auxiliary in formulating plans and typing the blood of prospective donors.—Mrs. C. Duncan Stewart, Press Reporter.

Mrs. C. F. (Esther) Crain, Corpus Christi, Texas, died June 14, 1946. Besides her husband, she is survived by a son, Peter Jefferson Crain, a midshipman at Annapolis.

Orange County Auxiliary met November 6 in the home of Mrs. Oliver Seastrunk, Orange, with Mrs. C. B. Shaddock as cohostess. Mrs. Seastrunk presented Mrs. L. C. Shipman, executive secretary of the Orange County Tuberculosis Association, who discussed the control of tuberculosis in the county. A dessert course was served to nine members and one guest.

Tom Green-Eight County Auxiliary met at the San Angelo Country Club on November 4 with twenty-four members present and Mrs. R. M. Arledge, president, presiding. The program was in observance of "doctor's day." A total of $18.50, to be divided equally between the Doctors' Memorial Fund and the Medical Student Loan Fund, in memory of the late Dr. C. E. Mayes, San Angelo, was collected. It was voted to donate $5 to the tuberculosis association. Mesdames Harvey Williams and Clay H. Johnson were accepted for membership. Coffee, sandwiches, and cake were served to the auxiliary members and their husbands by Mesdames R. M. Finks, Cecil French, Gordon Madding, Murray Wood, J. V. Sessums, Leon Hutchins, and Carl Kunath.

Travis County Auxiliary held its first meeting of the year October 15 in Austin. A luncheon was held in honor of Mrs. George Turner, El Paso, State Auxiliary president, who spoke on the objectives and aims of the Auxiliary. Special emphasis was placed on a study of current economic and social conditions.—Mrs. Virgil S. Rabb, Publicity Chairman.

Washington County Auxiliary observed "doctor's day" by entertaining the medical society with a barbecue supper October 28 at the dairy farm home of Dr. and Mrs. W. F. Hasskarl. Guests inspected the dairy farm and played games, in which the women were declared winners over the men.—Mrs. W. F. Hasskarl.

Fourth District Auxiliary met October 23 in Brady at the home of the president, Mrs. D. W. Jordan, for a business session, book review, and tea hour. The auxiliary met jointly with the medical society for lunch and dinner at Hotel Brady. Following the invocation by Mrs. Glenn Ricks, Brady, new officers were elected as follows: Mesdames John Nichols, Coleman, president; Charles Bailey, Ballinger, vice-president; Francis M. Burk, Coleman, secretary; Ben M. Shelton, Brownwood, treasurer; Glenn Ricks, Brady, publicity secretary; and Victor Schulze, San Angelo, parliamentarian.—Mrs. H. B. Allen, Publicity Secretary.

Eighth District Auxiliary heard Mrs. George Turner, El Paso, State Auxiliary president, when it met October 18 at the home of Dr. and Mrs. S. H. Kirkham, Columbus. Mrs. Turner considered the objectives of the Auxiliary in her talk. Mrs. James H. Wooten, Jr., Columbus, president of Colorado-Fayette Counties Auxiliary, presided. The Colorado-Fayette Auxiliary was host at a tea hour during which guests were served refreshments from a table decorated in the Halloween motif. Mrs. P. R. Denman, Houston; seven members of the DeWitt-Lavaca Auxiliary; six of the Wharton-Jackson-Fort Bend-Matagorda Auxiliary; and seven of the Colorado-Fayette Auxiliary were present in addition to Mrs. Turner.

Eleventh District Auxiliary met October 24 in Palestine, first joining the medical society for lunch at the Meadowbrook Country Club and then adjorning to the Blue Moon Inn for a business session and social hour. Mrs. George M. Hilliard, Jacksonville, president, presided. Mrs. R. H. Hodge, Athens, read the minutes; Mrs. J. M. Travis, Jacksonville, gave the treasurer's report; and county auxiliary activities in Smith, Henderson, and Cherokee Counties were presented. Mesdames C. E. Willingham, Tyler; R. T. Travis, Jacksonville; and R. H. Hodge, Athens, were appointed a nominating committee. Mrs. L. B. Windham, Tyler, first vice-president of the State Auxiliary, reported on the State Executive Board meeting in Fort Worth on October 30. She invited the district auxiliary members to Tyler for a meeting at which Mrs. George Turner, El Paso, State Auxiliary president, will speak. Announcement was made that the next district meeting will be in Tyler next spring.—Mrs. T. A. Stevens, Reporter.

Thirteenth District Auxiliary met in Graham on October 24 with sixteen members present. After luncheon with the medical society, the auxiliary heard Mrs. Nora Ellington, Graham, review "The Emperor's Physician" by J. R. Perkins. Mrs. Ellington presented the review when it was learned that Mrs. A. B. Pumphrey, Fort Worth, chairman of the Legislative Committee of the State Auxiliary, the scheduled

speaker, could not be present. Mrs. Tom B. Bond, Fort Worth, discussed cancer control, giving information about and warning against the disease.—Mrs. P. M. Kuykendall, Secretary.

DEATHS*

Dr. **Samuel Elihu Cramer**, Electra, Texas, died in a Dallas hospital September 27, 1946, of cerebral hemorrhage following an illness of several years.

The son of Samuel Joseph and Susanna Abbie (Connor) Cramer, Dr. Cramer was born March 25, 1881, at Daingerfield, where he received his preliminary education. He attended Tulane University, New Orleans, and the old Gate City Medical College, Texarkana, Ark. He served an internship at Charity Hospital, New Orleans, and practiced for a short time at Noonday, Texas, and Daingerfield before moving to Electra in 1908. Dr. Cramer practiced many years in Electra before his retirement.

DR. S. E. CRAMER

Dr. Cramer was a member of the Morris County Medical Society during his residence at Daingerfield and of the Wichita County Medical Society after his location in Electra. He was a member of the State Medical Association almost continuously throughout his professional career and was elected to honorary membership in 1933. He was also a member of the American Medical Association. He served as city health officer in Electra for several years. As a boy, Dr. Cramer acted as page for the Twenty-Fourth Legislature in Texas, during the administration of Governor James Stephen Hogg. He was a member of the Presbyterian Church.

June 16, 1909, Dr. Cramer married Miss Faye Cahill, who survives. Also surviving are one son, S. J. Cramer, Grand Prairie, and two grandchildren.

Dr. John Carr Garrett, Huntsville, Texas, died October 20, 1946, of gunshot wounds inflicted as he was about to enter a house to make a professional call. The estranged husband of the patient committed suicide after shooting Dr. Garrett.

Dr. Garrett, son of the Rev. C. E. and Addie (Carr) Garrett, was born in Bremond, May 23, 1914. He attended high school at Huntsville, received his academic education at Sam Houston State Teachers College, Huntsville, and was graduated from the University of Texas School of Medicine, Galveston, in 1938. He interned at John Sealy Hospital, Galveston, and then opened his practice at Huntsville. From June, 1943, until April, 1946, Dr. Garrett served with the Army Medical Corps, first receiving a commission as captain and being discharged from service as a major.

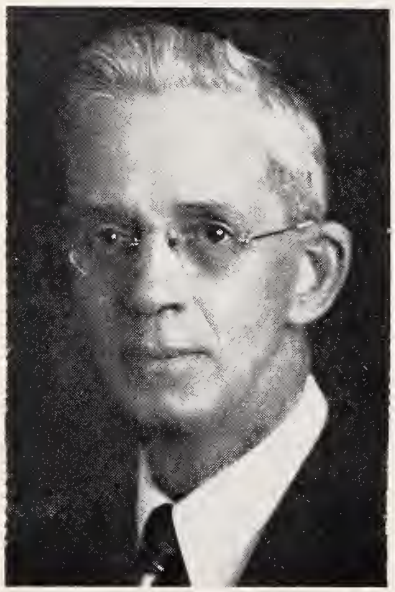
DR. JOHN CARR GARRETT

During his professional career Dr. Garrett was a member of the State Medical Association and American Medical Association through Walker-Madison - Trinity Counties Medical Society. He was president of the county society in 1942. He was a member of the Methodist Church, Alpha Omega Alpha honorary medical fraternity, Phi Beta Pi, Masonic order, and the Kiwanis Club.

Surviving Dr. Garrett are his wife, the former Miss Marie Stubblefield, whom he married July 5, 1939, at Paris; his father, the Rev. C. E. Garrett, Huntsville; and his mother, Mrs. Addie Carr Garrett, Houston.

Dr. Simeon Harrison Newman died of heart disease at his home in El Paso, Texas, on October 4, 1946.

Dr. Newman, son of Simeon Harrison and Jessie (Geck) Newman, was born August 31, 1888, in El Paso where he attended high school. He was graduated from the University of Texas School of Medicine in 1912, and served an internship at the Hudson Street Hospital, New York. The next few years Dr. Newman served as physician for mining companies in Mexico and Chile. In 1916 he was commissioned a first lieutenant in the Army Medical Corps, and after receiving basic training at Fort Riley, Kan., he was assigned to a hospital train in France, where he served from July, 1917, to April, 1919. After his



DR. S. H. NEWMAN

*An obituary ordinarily will not be published more than four months after date of death. Coöperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

release from the Army, Dr. Newman returned to El Paso, where he was in practice until his death.

Since 1920 Dr. Newman had been a member of the State Medical Association and American Medical Association through El Paso County Medical Society. He served two terms as president of the City-County Health Board.

Dr. Newman married Miss Willie Lea Montague on November 9, 1914, in El Paso. Surviving are his wife; a daughter, Miss Frances Montague Newman, New York, N. Y.; two sons, Simeon Harrison Newman, III, and Fletcher Campbell Newman; one brother, Lee Newman, and one sister, Mrs. C. A. Longuemare, all of El Paso.

Dr. Alfred Iverson Folsom, Dallas, Texas, was killed in an automobile crash near Dallas on October 3, 1946, when he was returning from a meeting of the South Central Urological Society in Hot Springs, Ark. Mrs. Folsom was badly injured in the accident.

Dr. Folsom was born May 9, 1883, at McGregor, the son of Dr. Alfred Iverson and Mary Frances (Powell) Folsom. His parents died when he was a boy, and he moved to Waxahachie to live with an uncle. After securing his preliminary education at McGregor and Waxahachie, Dr. Folsom received a bachelor of arts degree from Southwestern University, Georgetown, in 1904, and a doctor of medicine degree from old Southwestern Medical College, Dallas, in 1908. He later did postgraduate work at Rochester, Minn., specializing in urology. Dr. Folsom began practice at Alba, Texas, but moved in 1910 to Dallas, where he shortly turned to the specialty of urology, in the practice of which he was active until his death. He was a pioneer urologist in the Southwest and an accepted authority in this field. A forceful and interesting speaker, he was in great demand for medical programs.

DR. ALFRED IVERSON FOLSOM

Continuously throughout his professional life, Dr. Folsom was a member of the State Medical Association, and American Medical Association, for a short time through Wood County Medical Society and for many years through Dallas County Medical Society. He served as secretary of the Section on Surgery of the State Medical Association in 1922. He was a fellow of the American Medical Association, a member of the American Board of Urology since its organization, a fellow of the American College of Surgeons, and a member of North Texas District Medical Association and Dallas Southern Clinical Society. He was past president of the Texas Surgical Society and the South Central Urological Society and was president of the American Urological Association at the time of his death. For many years he was professor of urology and head of the Department of Surgery of Baylor University College of Medicine in Dallas before its removal to Houston. He was professor of urology at Southwestern Medical College, Dallas, from the time of its establishment until his death. He had been chief of the urology department of Parkland Hospital since 1923 and of the urology department of Baylor University Hospital for a number of years, having been on the staff more than thirty years. He was also a member of Baylor's medical board. He was honorary professor of urology at the University of Guadalajara, Guadalajara, Jalisco, Mex. He was a member of the Methodist Church, Kappa Alpha fraternity, and Dallas Country Club.

Preceding Dr. Folsom in death January 12, 1938, was a first wife, the former Miss Ann Rebecca Hodge, whom he married September 29, 1909. Survivors include his present wife, Mrs. Erma Folsom; one son, Alfred I. Folsom, Jr., Chicago, Ill.; and two daughters, Mrs. George Crofford, Jr., and Mrs. J. O. Neuhoff, both of Dallas.

Dr. I. D. Russell, Burkburnett, Texas, died at his home August 27, 1946, following an illness of three months.

Born in 1871 at Sulphur Springs, Dr. Russell moved to Winnsboro at an early age. He was graduated from Baylor University College of Medicine, Dallas, in 1912, and later did postgraduate work at Tulane University, New Orleans, and in Chicago. Starting his practice at Edgewood, Texas, he moved to Petrolia in 1908, practiced a short time in Wichita Falls, and then in 1918 located in Burkburnett, remaining in that town until his death.

DR. I. D. RUSSELL

Throughout his professional career Dr. Russell was a member of the State Medical Association and American Medical Association, first through Van Zandt County Medical Society and Clay County Medical Society, and then through Wichita County Medical Society. He was a member of the Wichita County Tuberculosis Association, local surgeon for the Missouri, Kansas and Texas Railroad, and city health officer for a number of years. He was a member of the Methodist Church, a Mason, and a member of the Lions Club.

Survivors include Dr. Russell's wife, the former Miss Ruby Kendall, whom he married May 30, 1923, in Birmingham, Ala.; one son, J. C. Russell, Long Beach, Calif.; three daughters, Mrs. Clyde Gibson and Mrs. Luther Bell, Wichita Falls, and Mrs. Ruby Nell Bowman, Burkburnett; two sisters, Mrs. L. B. Carrington, Waco, and Mrs. J. T. Freland, Dallas; a nephew, Dr. A. D. Pattillo, Wichita Falls; five grandchildren; and one great granddaughter.

Texas State Journal of Medicine

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Vol. XLII **January, 1947** **No. 9**

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION AND PUBLIC HEALTH IN TEXAS

First Interim Session of American Medical Association House of Delegates was held in Chicago, December 9-11, 1946. It will be recalled that the House of Delegates at the San Francisco session, last July, decided that there should be such a meeting, in order to relieve members of the House of the burden, stress and strain of the usual annual meetings of the House. There simply has all along been entirely too much work for one meeting. True, called meetings always could be held, and such meetings have been held, but the scope of such a meeting is limited. It was thought that the accomplishments of a midwinter meeting would justify the expenditure of time and money required to hold such a meeting, and it evidently has turned out that way. Everybody seemed pleased with the results of the first meeting. Practically every Delegate, or his Alternate, was in attendance, and much was accomplished in the three days of the meeting.

Texas was represented by its regular Delegates, Drs. Holman Taylor, Fort Worth; F. J. L. Blasingame, Wharton; R. B. Anderson, Jr. (acting for Dr. H. R. Dudgeon, Waco, and his Alternate, Dr. E. W. Bertner, Houston, neither of whom could attend the meeting); B. E. Pickett, Sr., Carrizo Springs; and E. H. Cary, Dallas. In addition to the regular delegation, the following Texas Fellows were seated, representing Scientific Sections: Drs. Charles T. Stone, Section on Internal Medicine; C. F. Lehmann, Section on Dermatology and Syphilology, and H. E. Griffin, representing the newly established Section on General Practice. Dr. Blasingame served on the Reference Committee on Miscellaneous Business, and Dr. Taylor was a member of the Reference Committee on Executive Session.

The minutes of the three-day session were published in full in *The Journal of the American Medical Association*, December 21, and December 28, 1946, and January 4, 1947, numbers. Because of the wealth of information included in the minutes, and the significance of the decisions made by the House of Delegates at this meeting, these minutes should be studied by all who are interested in the problems of medicine and the public health, and particularly of organized medicine, to use a term which is understood by all. For years it has been the policy of the JOURNAL, to editorialize on the Transactions of the annual meetings of the American Medical Association House of Delegates, which editorial has always represented the concensus of our representatives at the meeting. This discussion is presented in line with that policy. The necessity for brevity will militate against a complete discussion, but it is hoped to say enough to interest many of our readers in the matters under consideration.

The Rich Report was perhaps the most exciting topic for discussion at the meeting. Much was said about this report at the San Francisco meeting of the House of Delegates, and because of the amount of secrecy and restraint exercised at the time, particularly in view of the fact that the report was critical of the management of the American Medical Association, much curiosity was aroused. The report was by way of an "efficiency"

report, and many recommendations as to changes in management had been made. The Board of Trustees advised that some of the recommendations of the report had already been put into effect, and that others were being inaugurated. There had not been time enough for a thorough study of the report and for the necessary efforts at implementation, not to mention the time necessary to do a good job of separating the sheep from the goats in the recommendation herd. The Rich Report was laid before the House of Delegates at the mid-winter meeting under confidential cover, and in copyright form. Each Delegate signed for his own copy, and all were warned that none of the report could be published without permission of the proper authority at American Medical Association headquarters. A study of the report disclosed that, after all, the criticisms and recommendations were not particularly objectionable, although many of them were based upon lack of information, or, indeed, false information, and except for the fact that the opposition would probably distort and make improper use of the confidential discussions in the report, there would have been no sense in its suppression. It will be remembered that during the pendency of this report as a highly secret document, hearings on the Wagner-Murray-Dingell bills were in progress, and scientific medicine was under fire, including sniping, ambush, and strafing fire, not to mention the potentially embarrassing involvement of the National Physicians Committee. It is well enough that the situation was handled as it was.

Much of the discussion of the report hinged upon what was believed to be improper or inadequate public relations. Our experts felt that we had overlooked a bet in not featuring scientific medicine more dramatically. It was suggested that our lay publication, *Hygeia*, should be vitalized to that end. The Editor-in-Chief of the American Medical Association publications was expected to do all of that, and the problem was, in fact, assigned to him, with the aid of a special bureau or department of the Association, headed by a public relations expert and directed by the General Manager of the Association. All of this had become an accomplished fact. Indeed, the recommended reorganization had been partly accomplished at the time of the San Francisco meeting. Incidentally, a highlight of the report was the recommendation that the Editor of *Hygeia* reserve some of his vivid and popular articles exclusively for publication in *Hygeia*. Nothing was done about that. However, the recommendation that these and all related matters be placed in charge of an Executive Assistant to the General Manager of the Association, which Executive Assistant would function under the direction of the General Manager in all things, was approved. As a matter of fact, such an assistant had already been appointed and he was hard at it at the time of the mid-winter meeting. An important development in this connection was the decision that this official should be responsible for properly coördinating the activities of all councils and committees of the Association which had to do with the public. This was in accord with the recommendations of the efficiency experts, and was believed to be a safe and sound procedure so long as it was under the direction of the General Manager of the Association, and of the Board of Trustees. It had been recommended that two additional "councils" be set up to formulate public health programs for the public health and for schools. The idea was approved, but committees instead of councils were decided upon. Some felt that we have too many councils now. It was specifically provided that permission to attend meetings of councils and committees of the Association must be secured through the General Manager.

The criticisms by the Rich Report of the National Physicians Committee were held to be without sufficient documentation. Indeed, the committee in charge of the discussion in the House of Delegates called attention to the fact that the House of Delegates had on two previous occasions endorsed and commended the work of the National Physicians Committee. The special committee in charge said that the decision that the American Medical Association should do most of its own public relations and legislative work implied no lack of appreciation of similar work done by the National Physicians Committee. It was recommended that a further study of that portion of the Rich Report be made and in this connection, the decision was reached that the Association should accept such help from any proper organization. Each council and bureau was directed to identify all legitimate organizations of the sort in their respective fields, which are interested in their work, and establish practical cooperative relations with them.

The Rich Report made a number of recommendations about medical economics, prepayment plans, and public health education. It was decided that an executive should be employed who is of such caliber that he could direct all such activities, but at the same time it was directed that these, as in the case of other enterprises of the Association, be always implemented by and with the consent of the General Manager and constituted medical authority. It seemed to be the view of the Rich associates, as it is of everybody else, that doctors are poor business men, but even so, it is quite clear that doctors have accomplished much even in the field of economics, and it is believed that the opportunities for full medical knowledge are rarely given to nonmedical men. It was thought best to keep our activities within medical bounds.

The recommendation was made that there be set up in *The Journal* and *Hygeia* departments for the "expression of diverse views," the idea being that everybody should have an opportunity to express to everybody else, any thought pertaining to the policies of the American Medical Association. It was freely granted by those who discussed the matter that, properly directed, such a procedure would be quite worth while if it could be brought to a practical point of operation, but the chances of eluding and evading the crack-pots and such ilk appeared to be too remote at the present time. It is a fact that considered criticisms and differences of views have all along been given expression.

One recommendation that almost got lost in the shuffle was that while the present policies of the American Medical Association are that all prepayment plans of distribution of medical service be exclusively under medical direction, it might be well to modify the requirements to some extent, and it was so decided. Directives in the matter will be issued by proper authorities in due time.

Another point urged very strongly by the Rich associates was that in the proposed greatly extended activities of the Bureau of Health Education, a field secretary be employed to "carry the news to Garcia." It was decided that if and when conditions required

such activities, such an official would be employed. It is planned immediately to overhaul and revise the scientific and health publications of the Association, suppressing any which may be found to be outmoded.

There was much more, but it is impossible to discuss every item. Again we say that most of the things recommended by the Rich Report were already in hand, or due to be handled in due course. However, it is still a fact that it is an ill wind that blows no good.

Prepayment Medical Care Plans have, apparently, grown in number and scope during the past several months. The Council on Medical Service reported that seventeen plans were started in five states during the year 1946, which brings the total number of such plans now operating to over eighty in thirty-three states, Hawaii, and Puerto Rico. Plans are being developed in thirteen different states and the District of Columbia. It is anticipated that the number of participants in such plans will soon reach the 5,000,000 goal. As reported at the last meeting of the House of Delegates, an organization, the Associated Medical Care Plans, Incorporated, has been set up on a national basis, to help develop and coördinate the numerous such plans being attempted throughout the country.

Rural Medical Service is a related problam which is in the hands of a capable and active committee. There is some difficulty in fitting the prepayment plans into the rural situation, but the committee in charge and the Council on Medical Service will make an effort. It is not always easy to induce well qualified physicians to locate in rural communities, for obvious reasons. Neither is it always possible to furnish hospital facilities in such centers. Nursing needs are a problem, and so on down the line. It is expected that the enactment of the Hill-Burton bill into law will prove quite helpful in this connection. Through all of these encouraging activities, it is expected that the Principles of Medical Ethics will be respected. The Judicial Council called our attention to the matter at this meeting. It was pointed out that while the success of coöperative prepayment plans depended a good deal upon the solicitation of members, it still remained a fact that solicitation of patients, either by individuals or groups, is forbidden by the Principles of Medical Ethics. The Judicial Council also pointed out that "The division of income given to members must be in proportion to the value of the services contributed by each individual participant," and that "To divide the income of the group equally after deducting expenses would be in fact the division of fees which is not only unethical but in violation of the laws of some localities." It was pointed out, further, that the ethical principles involved apply not only to individuals, but to any collection of individuals.

Health Centers, a live subject right now from a number of angles, were well defined by the Council on Medical Service. It said that "a health center is an institution in a community which houses the public health functions of a community which makes available to the medical profession equipment and technical personnel to aid in the prevention, diagnosis and treatment of disease."

In the Hospital Survey and Construction Act, a public health center is defined as "a publicly owned facility for the provision of public health service, including related facilities such as laboratories, clinics and administrative offices operated in connection with public health centers." In the operation of such public health centers the coöperation of county medical societies is set out as the first desideratum. The extent to which the local medical profession shall make use of the services of a health center is to be determined locally. Emphasis is to be placed on the basic principle that diagnosis, treatment, and medical care of the individual is not a function of a health center, but of the medical profession. Neither is it contemplated that beds provided for use in public health centers shall be used to the exclusion of beds in established hospitals. They are emergency institutions. Radiologic, pathologic, and other laboratory services in public health centers are for the purpose of supplying such services where they may not be had otherwise. These and other such problems require that public health centers function with and by the advice of the medical profession locally, and presumably hospital management. These problems are going to be of importance in connection with the operation of the Hill-Burton bill sooner or later, as they are even now in a good many particulars, all of which places a serious responsibility and burden upon the medical profession where such facilities must be provided.

Industrial Health and Workmen's Compensation were given extensive consideration and much thought. These two subjects are common to most of the public health and economic activities of the medical profession at this time, and the report of our Council on Industrial Health and, in fact, of several of the bureaus and councils, have had to do with the ramifications of the subject. Each report is replete with information and interest. Indeed, the reports of all of the councils and bureaus were exceptionally good this year. They gave to the House of Delegates necessary information, and in such a way as to engage the attention of members of the House, thereby inspiring considered action.

Perhaps the most timely address offered at the meeting was that of Rear Admiral J. T. Boone of the Medical Corps of the United States Navy, who dealt with the coal mine problem from the angle of curative medicine and public health. Admiral Boone has been in charge of these matters since the mines were taken over by the Federal Government. He is of the opinion that mine physicians are too busy to permit them to do much in the way of preventive or public health medicine. His studies have led him to feel that there is a definite schism between curative and preventive medicine. It will be remembered that the mines are contributing 5 cents a ton royalty from the coal they produce and sell, and the unions are likewise making contributions. Enormous sums are thus collected and devoted to retirement benefits and welfare, including medical service. The problem from the medical angle has fallen into the lap of our Council on Medical Service. The House of Delegates is very insistent that there should be medical representation on any board of trustees that now have, or may in the future have control of these funds. Our Council on Industrial Health has been directed to work to that end. This Council is in close touch with the situation and those who have control therein.

National Legislation was covered in a very fine report from the Bureau of Legal Medicine and Legislation, and also received considerable attention in the so-called Rich Report. The Rich Report recommended that the Association become "legislation conscious." The House of Delegates, while impressed with the necessity of doing something about federal legislation, and doing it adequately, did not feel that there should be too much departure from its scientific objectives. It was rather generally felt that the present arrangements for aiding in proper medical and public health legislation are good, and if not efficient, are by way of becoming so under the rather general scheme of reorganization of the Association.

The most important piece of national legislation from the angle of the medical profession was, of course, the Hospital Survey and Construction law (Hill-Burton bill). State medical associations were urged to take it upon themselves to see that the parts of the law to be cared for at state level are

adequately cared for. Many of the states, including Texas, have done at least something along these lines. The need of state hospital licensure laws was emphasized, although the Hill-Burton law does not require anything of the sort. Adequate standards are important. Who is to determine such matters should be agreed upon, and, of course, uniformly throughout the country. It will be remembered that the American Medical Association and most of the state associations, had approved the Hill-Burton bill, and are coöperating in making the law a success. The Council on Medical Service, under the direction of the Board of Trustees, has issued a very extensive set of principles to govern coöperation under the Hill-Burton law. They are too long to analyze here. They are important.

The Work of the Several Councils of the Association has evidently been exceptionally good in the recent past, particularly that of the Councils on Pharmacy and Chemistry, Physical Medicine, and Industrial Health. The Board of Trustees rendered a full account of their services. We are prone to become negligent in such matters, depending on these devoted groups to do their respective jobs and expecting them to do them well.

The American Medical Association Publications are evidently succeeding, each in its field. *The Journal of the American Medical Association* has reached the highest point of circulation in history, approximately 130,000 weekly. The health magazine, *Hygeia*, has had to take the brunt of a shortage of paper, but that publication, which in January, 1946, could print only 155,000 copies, is expected to print 200,000 in January, 1947. It will be remembered that the Rich Report was critical of the failure of *Hygeia* to reach all of its objectives, and made recommendations with regard to the matter, which recommendations were toned down considerably before they were accepted. While no new Directory can be issued now, it is confidently expected that there will be enough paper available for the purpose before too long. The last edition was that of 1942. A revised edition of this important publication is very much needed.

Membership and Fellowship were both reported on the increase. The number of members December 1, 1946, was 129,145, an increase of 3,674 since December 31, 1945. On December 31, 1945, there were 67,567 Fellows. On December 1, 1946, there were 71,553 Fellows, an increase of 3,986 in eleven months.

This was not a regular annual meeting, hence the Report of the Board of Trustees did not involve finances.

Medical Education received exceptional attention at this meeting. The report of the Council on Medical Education and Hospitals was informative, as it always is, but some of the matters dealt with are particularly apropos just now. It will be recalled that a Scientific Section on General Practice was established in 1945 and held its first meeting in 1946, at San Francisco. It seems that the general practitioner had about been lost to view in the fog of specialists. It had come to the point where a physician could hardly secure worth-while preferment at all, except he were a licentiate of some specialty board. Some years ago, several resolutions were introduced in the House of Delegates leading to the designation of the specialty of General Practice. Nothing came of it. Dispersion of medical knowledge among general practitioners was too great. Since that time it has become evident that except and unless the general practitioner is given some such recognition as that given the specialists, very soon there won't be any general practitioners of medicine, and there are those who feel that the perpetuation of medicine both as a science and an art, particularly the latter, depends upon the family physician who, of course, is a general practitioner. The effort was made at this meeting of the House of Delegates to bring about the establishment of a National Board of General Practice. The matter was referred to our Section on General Practice for recommendation. Something will probably be done about it at the Atlantic City meeting in 1947.

A list of specialty boards (15) was submitted by the Council on Medical Education and Hospitals, together with recommended revision of essentials for approved examining boards in the specialties. There is an Advisory Board for Medical Specialties, to which Board these recommendations were referred after receiving approval by the House. A resolution was introduced requesting the specialty boards to issue certificates to physicians who had practiced their respective specialties for as much as fifteen to twenty-five years. The resolution was not adopted, the opinion prevailing that the specialty boards were doing all that they could do by their old-timers and, incidentally, applicants for certification whose qualifications were mainly incident to war service. The decision of the Association at San Francisco in July, to recommend that each hospital set up a Section on General Practice, was reiterated and emphasized. Except for some such provision, general practitioners may not be able to secure positions on hospital staffs. It was also recommended that the criteria for membership on hospital staffs of all specialties, including general practitioners, should not depend upon qualification by any specialty board. The competency of the physician should govern.

The Council on Medical Education and Hospitals recommended that the "Essentials of an Acceptable School for Laboratory Technicians" be changed to read, instead, "Essentials of an Accepted School for Medical Technologists." It may be news to some that there are such essentials, but we will all agree that something of the sort is necessary.

A resolution was introduced calling attention to the disparity between the number of internships and residencies in hospitals and applications for such positions, which has forced some hospitals to compete for applicants for such training on a monetary rather than an educational basis, and recommending that a "reasonable and uniform maximum figure for the remuneration of interns and residents be established, so that the monetary value of internships and residencies may not act as a deciding factor" in such applications. The resolution was approved, and referred to the Council on Medical Education and Hospitals for its guidance.

A resolution pertaining to the teaching of preventive medicine and public health to undergraduate medical students was approved and referred to the Council on Medical Education and Hospitals with the recommendation that the resolution be employed as a basis for a thorough study in that field. There is some criticism of the way this subject is taught in some of the schools in that prophylaxis and prevention of diseases are more or less detached from the general practice of medicine, where prevention should prevail.

"The Committee on Postwar Medical Service," which has rendered a very valuable service in reconversion, has been continued as the "Joint Committee for the Coördination of Medical Activities." The Joint Committee is made up of committees of the American Medical Association, the American College of Surgeons, and the American College of Physicians, and members from a large number of other groups having to do with medical education and the practice of medicine.

A resolution calling specifically for coöperation between the medical and dental professions was also approved, and the whole matter referred back to the Board of Trustees.

A resolution approving the study of child health

now being made by the American Academy of Pediatrics was referred to the Council on Medical Education and Hospitals without recommendation. It will be recalled that the House of Delegates of the State Medical Association of Texas referred the same matter to the Texas Pediatric Society, and subsequently approved the survey upon the recommendation of that organization.

A resolution was passed declaring that the presentation of bills and the collection of private fees for medical service rendered by other than recognized physicians, be considered as evidence of the practice of medicine, and declaring such persons liable to the penalties set forth in medical practice acts. The resolution pertained to the practices of anesthesiology and other specialties in medicine which are at times ignored as such. The Reference Committee having the resolution in charge rewrote the same, resolving, after reiterating the facts set up in the original resolution, that the practice of anesthesiology is the practice of medicine, and that the presentation of bills and collection of fees for such service shall be considered as evidence of the practice of medicine. It was further resolved to send the resolution to the agencies of each state having in charge the enforcement of medical practice acts.

Speaking of anesthesiology, a resolution was introduced in the House pledging the coöperation of the American Medical Association with the American Society of Anesthesiologists and other acceptable medical organizations, in programs celebrating the centenary of the first public demonstration of the use of ether as an anesthetic by W. T. G. Morton, in the Massachusetts General Hospital in Boston, October 16, 1846. Efforts to fix the discovery of anesthesia on the occasion mentioned in this resolution have heretofore and on several occasions failed in the House of Delegates. However, the celebration mentioned in the resolution was approved. It has reference only to the first demonstration.

Quite a stir was created in the House of Delegates over a resolution from Colorado, criticizing, in fact condemning, as a perversion of function and dereliction of duty, political and partisan activities on the part of officers of the United States Public Health Service, including its Surgeon General, and recommending that steps be taken to prohibit such political activities. The reference committee dealing with the resolution toned it down somewhat. It was finally resolved that the House of Delegates of the American Medical Association express its complete disapproval of the conduct complained of, particularly that of the Surgeon General. Some of our readers will remember occasions when such complaints were voiced by the medical profession of Texas.

Military Rank seems to be of importance to the medical profession in several particulars. At the San Francisco meeting in July, a committee was appointed to inquire into the general situation of military rank. This committee reported that plans were under way in the War Department to provide for more rapid and appropriate promotions of medical officers of the Armed Forces. The committee appointed consisted of four civilian physicians who served as medical officers in the war, and three others. This committee recommended that the title of the committee be changed to "Committee on National Emergency Service," and it was so ordered. The scope of the committee will be extended to many phases of military service, beginning with the premedic student and running through all medical activities, and covering the activities of the Procurement and Assignment Service as we knew it during the war. Among the activities of this committee is the circulation of a questionnaire among former medical officers of the Armed Forces, with the object of determining just what practices and procedures should be complained of and which might be corrected.

A resolution was introduced, calling for the appointment of a committee of distinguished American physicians to study, as occasion arises, the qualifications of physicians available for the positions of Surgeon General of the Army, Navy, Public Health Service, and Veterans Administration. It was provided that the committee should "advise the President of their considered judgment in these matters." The resolution was changed so as merely to notify the President of the United States and Cabinet Officers concerned, of the willingness of the American Medical Association to consider such matters and advise accordingly. It was also decided that more attention in future activities of the Procurement and Assignment Service should be given to the reservation of physicians for civilian practice.

The Veterans Administration came under discussion through a letter addressed to Dr. E. H. Cary, by a representative of the Department of Medicine and Surgery of the Veterans Administration, which letter was presented by Dr. Cary, together with a resolution intended to carry out some, if not all of the suggestions contained in the letter. The resolution provided that members of the permanent Medical Corps of the Veterans Administration be permitted to apply for Fellowship in the American Medical Association, independent of county medical societies, such Fellowship, if extended, to continue during the tenure of office of the applicant. Amendments to the Constitution and By-Laws of the Association were offered which would accept the officers of the permanent Medical Corps of the Veterans Administration under such conditions, and provide for that Corps representation in the House of Delegates. The purpose and purport of the resolution were readily approved, but the whole matter was deferred because of the fact that the changes called for require amendment to the Constitution and By-Laws. The special Committee on Amendments to the Constitution and By-Laws will report upon the proposed amendments to both in the next annual meeting of the House of Delegates.

A resolution was passed calling upon the Veterans Administration not to include the practice of anesthesiology, pathology, radiology, and physical therapy, as part of contracts with hospitals covering service to be rendered by the medical profession outside veterans administration hospitals.

Cancer Information Service, as proposed by the American Cancer Society, received the attention of the Council on Medical Service. The Council advised that the American Cancer Society controls only the distribution of funds, and of information to the public. All of the activities of the Society, according to its directives, are subject to approval by county medical societies. It is not the purpose of the Society to diagnose or treat cancer, but merely to distribute information which will help to do both. The Council on Medical Service was directed to request state medical associations to contact agencies which have under their care the dispersion of federal funds for the control of cancer, to the end that such funds may be administered wisely and in coöperation with practicing physicians.

The Centennial Celebration, plans for which have been under way for some time, will definitely be held at Atlantic City, in June, 1947. The Council on Scientific Assembly announced a scientific program which will honor the occasion. The history of medicine, which is now being compiled, and, incidentally, appearing in *The Journal of the American Medical Association*, will be featured. The Board of Trustees have planned a session on the history of medicine for inclusion in the Section on Miscellaneous Topics, to which the Council on Scientific Assembly has agreed, and will implement. Indeed, the centennial celebration has already begun through

the presentation by radio of programs pertaining to the important medical events during the past one hundred years. The material included in the programs thus broadcast are carefully checked, and carefully written. Events pertaining to the history of various states and regions of the United States are featured by the medical profession in such areas. The publicity incident to the occasion should be educational and helpful. The cause of medicine has too long been relegated to the medical profession exclusively.

War Crime Experiments made by the Germans, in particular, during World War II, have been variously condemned and condoned. Dr. A. C. Ivy, who had been sent to Europe as a representative of the United States Government to review war crimes of a medical nature, reported that none of the experiments complied with the Principles of Medical Ethics of the American Medical Association. Any such experiments, to be within the bounds of ethics, must be conducted by and with the consent of the person experimented upon; the danger involved should be investigated by animal experimentation, and the experiments should be performed under proper medical protection and management. Apparently none of these conditions was complied with. The Judicial Council so reported; the House of Delegates agreed and the practices complained of were condemned.

A Preliminary Conference of Officers of County Medical Societies to be held just prior to the annual meeting of the American Medical Association, for the purpose of bringing to the House of Delegates the diverse problems of the various localities thus represented, was proposed in a resolution from Indiana. The objectives of the proposed movement were generally approved, but the whole matter was referred to the Board of Trustees for further consideration and for recommendation. There were those who held that there is entirely too much confusion in this connection now. Such a meeting is now held each year, attended by a group more limited in the matter of areas covered, and it appears very doubtful whether anything has so far been accomplished by the movement.

The Woman's Auxiliary, having been mentioned in the Rich Report as a valuable supporting group, was commended, and an extension of the organization was recommended in a resolution. The resolution provided further, that the Woman's Auxiliary be furnished with a definite program, presumably meaning in connection with the public relations program of the Association. The resolution was adopted, and the Board of Trustees requested to outline and assist the Auxiliary in the guidance of its program. We hope this "guidance" will be diplomatically extended.

The Board of Trustees Acting as a Reference Committee was criticized, as a procedure, in a resolution from Utah. The resolution held that under the procedure complained of, matters might be referred to the Board of Trustees which originated with the Board, and therefore, the Board in acting as a Reference Committee would, in effect, be passing upon its own judgment. No action was taken, in view of the fact that the matter is definitely covered by the Constitution and By-Laws of the Association. The opinion seemed to prevail that the Board of Trustees while acting as a Reference Committee was meeting a requirement of the House of Delegates and not in any sense attempting to prejudge decision.

Revision of Constitution and By-Laws, as ordered by the House of Delegates at the San Francisco meeting, and referred to an especially selected, high-powered committee, was attempted, but only as pertained to the By-Laws. The committee held that it could not properly rewrite both the Constitution and By-Laws in the time available for the task. A very complete and comprehensive set of By-Laws were presented, however, and in such form that they would operate under the present Constitution until the Constitution could itself be revised. Much attention was given the matter, but final action was deferred until the next meeting of the House of Delegates, by which time, the hope was expressed, both Constitution and By-Laws would be ready and properly coördinated. However, one important change was made in the By-Laws. Heretofore the By-Laws have provided that no member of the House of Delegates, nor any general officer of the Association could be elected to the office of President-Elect or Vice President. On occasion, both delegates and officers have been asked to resign so that they could be nominated for President-Elect. There seemed to be no good reason why anybody should be barred from nomination to these high offices. The presumption that they might wield undue influence by virtue of their positions appeared to be rather ridiculous. The By-Laws were changed to remedy the situation accordingly.

Additional Tuberculosis Sanatoriums.—Urgently needed sanatorium beds for tuberculosis patients are provided for in a bill to be introduced in the forthcoming session of our State Legislature. The measure is published elsewhere in this JOURNAL (page 552). Such legislation has long been sought by the Texas Tuberculosis Association, supported by the State Medical Association of Texas and many other organizations. The bill, as recently revised and presented herewith, has been approved in principle by the Legislative Committee and the Executive Council of the State Medical Association, and in fact and in particular by the Texas Tuberculosis Association. It may be said, therefore, to be satisfactory in its provisions and purposes, whether or not it is so stated and so phrased as to meet the requirements of our Legislators who must vote upon it. It is believed that, except and unless the Legislature refuses to spend the money for the purposes set out in the bill, it will pass without a great deal of trouble.

The fact has heretofore been published in these columns that the State Medical Association will be glad to see this measure become a law. We believe the medical profession of the state will approve of the idea.

If this bill becomes a law, a sanatorium designed for the care and treatment of the tuberculous will be built in each of the two sections of the state having the greatest incidence of tuberculosis, namely, East Texas and Southwest Texas. One of them will be at some point in the First, Third, or Seventh Congressional District, the other in the Fourteenth or Fifteenth Congressional District.

The sum of $1,600,000 is to be appropriated to cover the cost of the two sanatoriums provided for, including sites, construction, and equipment.

The location of the two institutions will be made by the State Board of Control. The

sanatoriums will be operated, managed, and controlled by the State Board of Control, in the same manner as are other eleemosynary institutions of the state, which means that the State Board of Control will select the Superintendent, medical staff, and other employees, and establish terms and conditions of their employment.

The number of state, county, and private sanatorium beds at present available to tuberculosis patients in Texas is 1,525. The total number of deaths from tuberculosis annually approximates 3,000, and 68 per cent of these deaths occur not in institutions but in homes. The two sanatoriums for which appropriation is requested of the Fiftieth Legislature are obviously needed in the fight on the disease. It is hoped, therefore, that the individual members of the State Medical Association will support this legislation as actively as their time and talents may permit.

Library Needs of the State Medical Association.—In the Library Notes section of this number of the JOURNAL appears a new heading, "Library Needs." Under this heading it is planned to list from time to time miscellaneous items which the Library of the State Medical Association should have to complete its files. For example, in the first listing (page 554) are seven medical journals which are missing from otherwise complete sets in the Library and which it is hoped may be supplied by members of the Association, either by gift or by sale, so that the completed volume of the journal in question can be bound for permanent reference.

Frequently a physician has an odd assortment of back issues of journals which are of comparatively little value to him but which, when used to round out a set for the Library, can contribute immeasurably to the usefulness and value of the Library collection. It will be remembered that when material is placed in the Library, it remains available to the donor, so that while he helps the Library serve its many patrons adequately, he himself does not lose.

Readers of the JOURNAL are urged to make note regularly of Library needs as they are listed, and to assist whenever possible in reducing the number of "wanted" items.

A Child Health Services Survey is currently being carried on in Texas in connection with a nationwide study undertaken by the American Academy of Pediatrics. Pediatricians and others have realized that if children are to receive the care they need, systematic plans to provide such care must be made, and effective planning must depend upon knowledge of what type of care now exists. It has been considered that since physicians know what constitutes good care, they should develop the program.

The American Academy of Pediatrics some months ago announced its intention of assuming the responsibility for making a survey of child health services and requested the cooperation of every physician in gathering the necessary data. The blessings of the American Medical Association were given to the project, and the State Medical Association of Texas was asked for its support. The House of Delegates of the State Association, meeting in Galveston last May, recommended that endorsement by the State Medical Association be held in abeyance pending action by the Texas Pediatrics Society. Following approval of the survey by the Texas Pediatrics Society, the Executive Council of the State Medical Association, on September 29, 1946, unanimously endorsed the survey.

Questionnaires are being mailed to Texas physicians by Dr. Helen T. Konjias, Austin, executive secretary for the Texas study. The survey can be a real success only if each physician answers the questionnaire and returns it to Dr. Konjias. Data for Texas will be compiled on the basis of information from pediatricians, other physicians, hospitals, community health services, and dentists throughout the state, and the material from Texas will be used to complete the national survey. Surveys have already been completed in several states.

Despite the flood of questionnaires which constantly threaten to inundate the unwary, this particular questionnaire is commended to the physicians of the state. The medical profession has an opportunity to assist in a positive program of action. It is hoped that it will accept the challenge.

Local Committees for the 1947 Annual Session, to be held in Dallas, May 5-8, are announced this far in advance for the benefit of any member who may have need of their services. The annual session dates proper are May 6-8, inclusive, the House of Delegates being the only group of the Association to meet on May 5, which is Monday. All of the special societies which customarily meet conjointly with the State Medical Association will hold their meetings on May 5.

As previously announced, the Adolphus Hotel is headquarters for the State Medical Association and the Baker Hotel for the Woman's Auxiliary. All who plan to attend are urged to make hotel reservations without delay.

The Council on Scientific Work is scheduled to meet January 19, at which time final decisions will be made regarding all features of the annual session, and the scientific pro-

gram will be officially closed. Any member who has something he would like to contribute to the program either in a scientific exhibit or paper should by all means offer to do so, although no papers can be accepted after January 19 except to fill vacancies. The names and addresses of section officers were published in the November, 1946, JOURNAL, page 406.

Applications for space in the scientific exhibits or offer of a motion picture for the motion picture exhibits should be made promptly to Dr. X. R. Hyde, Chairman, Committee on Scientific Exhibits, Medical Arts Building, Fort Worth.

The local committees, including the General Arrangements Committee, which will serve and are serving in connection with the 1947 annual session, follow:

LOCAL COMMITTEES

General Arrangements.—Frank A. Selecman, Chairman; Edwin L. Rippy, Howard K. Crutcher, John L. Goforth, and C. D. Bussey.

Hotels.—Jack G. Kerr, Chairman; Murphy Bounds, Jo C. Alexander, Glenn D. Carlson, Alvin Baldwin, and Andrew Small.

Information.—Ramsay Moore, Chairman; Ben R. Buford, C. Frank Brown, Casey E. Patterson, L. M. Reaves, Taylor T. Pickett, William M. Lively, Jr., and Thomas S. Love.

Finance.—Davis Spangler, Chairman; F. J. Sebastian, Floyd Norman, Gordon Maddox, Samuel A. Shelburne, C. J. Paternostro, J. R. Maxfield, Floyd Franklin, and Ruth Jackson.

Memorial.—Elliott Mendenhall, Chairman; Nina Fay Calhoun, Milford O. Rouse, O. W. Gibbons, and L. C. Sams.

Clinical Luncheons.—Thomas E. Smith, Chairman; Robert L. Moore, John S. Bagwell, Robert Sparkman, James H. Herndon, Charles LaDue, J. G. Brau, S. A. Alexander, Morton L. Mazer, Ridings E. Lee, Cecil Stell, and M. M. Scurry.

Alumni Banquets.—Tate Miller, Chairman; Paul J. Thomas, Thomas Barr, Charles Duncan, and J. Hudson Dunlap.

Reception.—Everett C. Fox, Chairman; Edward White, Lee Hudson, A. R. Thomasson, Paul Williams, Henry M. Winans, H. Leslie Moore, Brandon Carrell, G. D. Mahon, W. L. Hart, Arthur Grollman, Lyle M. Sellers, Oscar M. Marchman, Sr., John Young, David Carter, G. E. Brereton, Guy T. Denton, Sr., Homer Donald, Curtice Rosser, Charles Martin, Marvin Bell, J. N. McLeod, Wayne T. Robinson, Elbert Dunlap, C. C. Nash, E. S. Gordon, Rufus Whitis, W. D. Jones, E. H. Cary, Minnie L. Maffett, Guy Witt, R. E. Van Duzen, and J. W. Bourland.

Entertainment.—Hall Shannon, Chairman; Dayton McBride, Halcuit Moore, Ruby Daniel, Louie Allday, M. K. McCullough, John L. Jenkins, John McLaurin, O. R. Caillet, Wallace Wilkinson, Hubert Hawkins, Archibald McNeill, and John Pace.

Golf.—H. A. O'Brien, Chairman; Robert B. Giles, S. M. Hill, J. H. McCracken, R. B. McBride, Robert M. Barton, and Kelly Cox.

Transportation.—T. M. Kirksey, Chairman; Richard A. Dathe, Raymond Willis, Sidney Galt, and Dudley P. Laugenour.

Scientific Exhibits.—John E. Ashby, Chairman; Howard E. Heyer, Charles T. Ashworth, Bruce A. Knickerbocker, Maxwell Thomas, Penn Riddle, Lawrence Sheldon, Barton Park, Dudley Singleton, Ben A. Merrick, and Merritt B. Whitten.

Technical Exhibits.—J. Howard Shane, Chairman; John Chapman, Walton Cochran, Sydney Baird, William P. Devereux, and William Fuqua.

Halls and Lanterns.—Guy T. Denton, Jr., Chairman; H. M. Spence, T. W. Bywaters, Felix Butte, Robert Carpenter, and A. M. Reagan.

Public Lectures.—J. H. Black, Chairman; W. Grady Reddick, Tinsley R. Harrison, Percy M. Girard, Gaston Harrison, J. W. Duckett, Cecil O. Patterson, and May Agness Hopkins.

Publicity.—George A. Schenewerk, Chairman; Robert Short, Alexander Terrell, G. Raworth Williams, Watt Winn, Harold Clark, and W. K. Strother.

CURRENT EDITORIAL COMMENT*

Irradiation Therapy of Inflammation.—Inflammatory diseases of infectious etiology are today treated with increasing effectiveness by antibiotics and chemical agents. A considerable variety of organisms is susceptible to their action, in varying degrees. For those infections in which the organism is more or less resistant to these agents, and for the many inflammatory processes of noninfectious origin, roentgen therapy is a valuable means of attack alone or as adjuvant to surgical and drug therapy. There are no known contraindications to the use of roentgen rays in infectious diseases, nor any incompatibilities with the chemotherapeutic and antibiotic agents.

It may be well to point out the harmlessness of roentgen radiations when administered with due regard for the duration of the inflammatory disease, and with proper dosage, fractionation, and spacing. The anti-inflammatory dosage is a very small fraction of the cancericidal dosage of roentgen radiation, and none of the occasionally unpleasant side-effects of the latter is, therefore, seen. As a rule, the more acute the process, the smaller is the therapeutic dose employed and the more rapid is the response, with either resolution or early fluctuation. Other factors influencing the quantity of irradiation are the site of pathologic disturbance, the type of surrounding tissues, ease of drainage, and the degree of regional vascularity. The quality of radiation is a matter of judgment by the radiologist and must vary with the depth of the disease being treated.

In therapy of infections, the nonspecific action of the roentgen rays is often an actual advantage. Their effect is to aid rapid localization and lysis of leukocytes in the inflamed

*This department of the JOURNAL presents editorial comments on current items pertaining to the science, art and practice of medicine, contributed by members of the State Medical Association and scientists closely associated with the medical profession of Texas. Invitation is hereby extended to any member of the State Medical Association of Texas to submit such discussions for this department. The discussions should not be more than 500 words in length.

area under treatment. An intense concentration of antibacterial enzymes, and possibly antibodies, is released, thereby affecting a wide range of organisms. The action in noninfectious inflammation is apparently caused by stimulation of absorption of the inflammatory elements locally, probably caused by stimulation of absorption of the inflammatory elements locally, probably due to favorable alterations in the vascular bed.

The wide variety of non-neoplastic conditions which can be affected favorably by irradiation is well attested in the literature and borne out in the experience of the qualified physician who practices therapeutic radiology. The amenable diseases range from such acute infections as parotitis, mastitis, erysipelas, mastoiditis, carbuncles, and deeper-seated infections to the more chronic conditions caused by virus or of unknown origin, such as the spondylitis of Marie-Strümpell, herpes zoster, "virus" radiculitis, tuberculous adenitis (including the abdominal type), and the diphtheria carrier state. There is evidence to indicate that radiation therapy causes a definite decrease in length and severity of the morbidity in atypical pneumonia of presumed virus etiology. In gas gangrene, too, radiation therapy has been used with gratifying effect in reduction of morbidity and mortality, fortifying the effect of sulfonamides and penicillin. A recent report of the development of B. welchii infection at the site of long continued injection of penicillin may indicate an inherent or acquired resistance of at least some strains of the organism to that agent.

Another field of usefulness in radiation therapy is the group of nonspecific and post-traumatic arthropathies and peri-arthropathies, including such disabling affections as peritendinitis (with and without calcification), bursitis, and some of the arthritides of the spinal and peripheral joints. Complete relief may be afforded, or at least a degree of relief from pain and spasm to a point where orthopedic corrective measures may be effectively adopted.

A claim for 100 per cent effectiveness for radiation therapy in all inflammatory conditions can no more be made than for any other therapeutic agent. However, the proven merit of this means of treatment, its ease of application, its availability in skilled hands in most populated centers today, and its usefulness even as a supportive measure with other agents indicate that it be more widely employed.

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INFECTIOUS HEPATITIS

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Infectious or epidemic hepatitis, with or without jaundice, acute or chronic, appears to be a disease that is caused by a filtrable virus usually present in stools and blood at least during the acute stages of the disease. Experimentally, the icterogenic agent has been transferred from one human being to another in stools and blood but it has never been demonstrated in a culture media, embryo, bird, or mammal. The excellent studies in experimental transfer of the disease from human to human by means of stools and blood, by Paul, Havens, McCallum, Stokes, Neefe, Oliphant, Francis, and their collaborators have gone far in the clarification of several important features in the knowledge of factors in the transfer of the icterogenic agent. Readers are referred to the excellent article by Havens and others[8] for an interesting review of that subject and to a general statement of the whole subject in an excellent recent editorial in *Annals of Internal Medicine*.[10] Clinically, infectious hepatitis is indistinguishable from the jaundice referred to as catarrhal or epidemic jaundice of children, the jaundice of campaigns of English camps, barrack jaundice of the French, and soldaten krankheit of the Germans.[4, 12, 19] This disease is not new to the Army of the United States since there were outbreaks during the American civil war during which Woodward[21] recorded 52,427 cases of jaundice from which 231 federal troops alone died in four years. This virus hepatitis is not to be confused with leptospiral (Weil's) disease of the liver. A lack of differentiation of these two diseases in the early literature on infectious jaundice clouds the record. Recently, the subicteric[2] delayed recovery and chronic forms of the disease have been recognized,[2, 3, 5, 6, 16] but the true incidence, complications, and late effects of virus diseases of the liver are yet to be established.[2, 3, 12] Meetings with or communications from doctors during the past six months suggest that infectious hepatitis is on the increase in the United States. It may be limited to a single case, or a whole family may succumb after some thirty to sixty days. Similar experiences are occurring in schools or other institutions, and Neefe and Stokes have reported a very interesting example.[15] This paper is to summarize some personal experiences with the recognition, course, and treatment of large numbers of cases of nat-

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urally acquired infectious hepatitis seen in several races in several armies and in civilians of different countries during the past four years.

INCIDENCE

Sharp outbreaks have been reported in Denmark, England, Finland, Germany, Holland, Norway, Sweden, and the United States in prewar years, indicating a widespread seeding of a large population prior to the massing of large numbers of susceptible young men in armies of the present war. Recent reports[2, 13] and personal observation indicate that infectious hepatitis is global in its distribution and that its incidence has increased notably during this war.[1] The German army suffered many more cases of infectious hepatitis than their Italian partners. The Chinese, Japanese, Ghurkas, Indians, Jews, Arabs, Cyprians, and Congoans were observed with the disease. The Brazilian Expeditionary Force appeared to have fewer cases than the Canadian and United States troops. If total case figures for the armed forces in the Pacific and Mediterranean Theaters are published, they will reveal in part the vast loss of manpower to Allied and Axis armies caused alone by the acute form of this disease.

Cases are encountered throughout the year, but the curve of incidence rises from midsummer, reaching its peak in late fall and early winter. This seasonable resemblance to poliomyelitis and typhoid diseases is noteworthy.

CLINICAL ASPECTS

Although sharp lines cannot be drawn, the clinical picture of infectious hepatitis may be roughly separated into prodromal, interval, icteric, convalescent, and rehabilitation periods. Case classification into acute hepatitis with jaundice, acute hepatitis without jaundice, and chronic hepatitis (including cases with slow recovery) are general descriptive clinical types. The latter two groups require emphasis since recent broadened clinical experience, multiple laboratory tests, and biopsies of the liver have revealed many more cases and many more details of pathologic conditions associated with slow recovery than had been suspected in the past.[3, 6] The more common symptoms experienced in these stages of infectious hepatitis are:

1. *Prodromal,* resembling any infectious disease such as
   a. Fever, chilliness, aching muscles.
   b. Headache, often marked and prolonged.
   c. Anorexia, cramps, soft stools, flatus.
   d. Lassitude and exhaustion.
   e. Less common: vomiting, urticaria, arthralgia, herpes labialis, somnolence, and rhinitis.
2. *Interval period,* usually afebrile with
   a. Lassitude, somnolence, exhaustion, mental depression; occasionally membranous tonsillitis.
   b. Anorexia, nausea, occasionally vomiting, flatulence, and loose stools.
   c. Right upper quadrant ache aggravated by jolting exertion.
   d. Less common severe abdominal pain simulating acute surgical abdominal condition.
3. *Acute stage.*
   a. Jaundice may or *may not* develop.
   b. Transient mild recrudescence of fever.
   c. Nausea, vomiting, and gastro-intestinal symptoms aggravated, especially in icteric patients.
4. *Convalescent period,* usually established in twenty to thirty days and characterized by
   a. Rapid decrease of nausea, vomiting, somnolence, and abdominal distress.
   b. Return of feeling of well-being and a voracious appetite.
   c. Decrease in liver tenderness.
5. *Delayed recovery and chronic stage,* characterized by continued symptoms, commonly
   a. Lassitude, ease of fatigue, or exhaustion.
   b. Right upper quadrant and right lumbar ache aggravated by jolting exertion.
   c. Anorexia, gas, flatus, fat intolerance, dyspepsia, cramps, loose stools.
   d. Headaches, mental depression, heart consciousness, sweating, and mixed complaints, all of which are easily confused with psychosomatic disorders.
   e. Weight loss and inability to gain.

PHYSICAL EXAMINATION

The commonest early physical manifestations are:

1. Temperature ranges from normal to 104 F.

2. Moderately injected conjunctiva and pharynx.

3. A marked tenderness of the liver demonstrated by palpation or by dipping the extended fingers into the right upper quadrant of the abdomen or by jolting with a closed fist of the lower thoracic cage over the liver region. The liver and spleen may be palpable in 20 per cent, but the soft rolled edge of the developing enlargement of the liver is best demonstrated by the pain response to "dipping" or direct percussion of the right upper quadrant of the abdomen. An easily palpable sharp-edged liver is rare in this disease. The spleen, if enlarged, rapidly becomes normal in size, ordinarily within seven days. A very dark foamy urine and a light colored stool may be noted.

4. A soft, nontender enlargement of the right inferior deep cervical, the right axillary and epitrochlear lymph nodes. The soft, nontender, freely movable posterior deep cervical node is most readily palpated, after rotation of the patient's head sharply to the left, by sliding the fingers gently along the posterior border of the sterno-cleido-mastoid muscle. Although the significance of this sentinel node is not clearly established, it should be recalled that it is in contact with the deep lymph channels to the dome of the

liver. This node is not found in all cases of infectious hepatitis, but it often heralds the appearance of jaundice by seven to fourteen days.

LABORATORY TESTS

The most helpful laboratory tests in the early stages have been:

1. A blood picture of leukopenia with a relative lymphocytosis in which are noted large vacuolated atypical lymphocytes resembling cells seen in infectious mononucleosis. They are especially helpful in detection of preicteric and nonicteric cases[2] (fig. 1 and 2).
2. Bilirubin and urobilinogen in the urine.[9]
3. A strongly positive modified Franke methylene blue test in the urine[2] (a green color after four or more drops of 0.25 per cent of methylene blue hydrochloride has been added to 5 cc. of urine).[7, 14]
4. Elevated one minute blood bilirubin (over .2 mg.) or a positive prompt direct van den Bergh reaction.[2]
5. A strongly positive (3 plus to 4 plus)

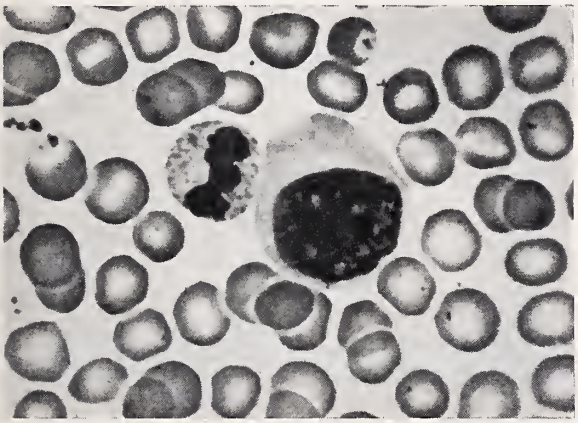

FIG. 1. Infectious Hepatitis—seven days pre-icteric. A leukopenia (5,000 to 2,500 leukocytes) with a relative lymphocytosis is common showing large atypical lymphocytes with deeply basophilic foamy vacuolated cytoplasm and red-tinted irregularly shaped nuclei which appear to have unevenly stacked or woven chromatin fenestrations. Smears taken seven to fourteen days before icterus contain 10 to 25 per cent of these abnormal or "toxic" lymphocytes (Dr. Hugh Wilson and Dr. Byrd Leavell) and they serve as a valuable diagnostic aid in the prodromal period. Lymph nodes are nontender and the heterophile agglutination test is negative. Note normal polymorphonuclear for comparison.

cephalin-cholesterol-flocculation test (Hanger) three to ten days prior to the appearance of icterus which usually remains strongly positive until the patient's acute symptoms subside or until about the time the prompt direct van den Bergh test begins to subside.[2] The thymol flocculation test of Maclagan may come to more general use in late stages.[20]

6. Increased serum globulin (2.5 to 5 Gm.) and serum phosphatase (5 to 15 Bodansky units) may appear simultaneously with the increased (qualitative) prompt direct van den Bergh test or the positive cephalin-cholesterol-flocculation precipitation. Such multiple observations are very helpful in patients who have not nor ever do become jaundiced. Again the sharp increase of the serum globulin without reduction of the serum albumin, resulting in an increased total serum protein (7.5 to 10 Gm. per 100 cc.) is in sharp contrast to the reduced serum

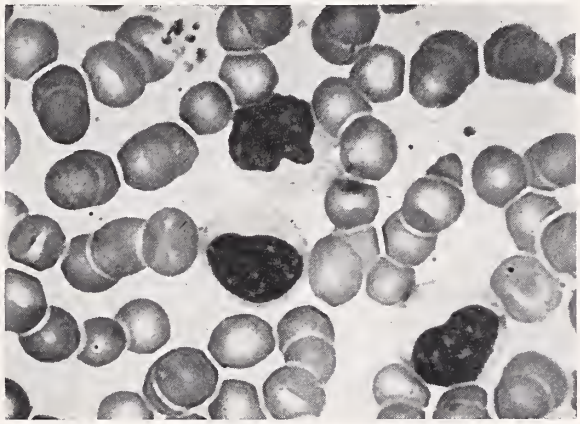

FIG. 2. Infectious Hepatitis—blood smear, fourth week. The large atypical, vacuolated lymphocytes may make up 20 to 80 per cent of the white blood cells during the height of infectious hepatitis. As the disease subsides, the atypical cells become smaller, deeper-staining, and less vacuolated while others appear to roll and disintegrate with return to a normal smear in five to eight weeks.

albumin and total proteins of patients with jaundice of chronic liver disease.

As the disease progresses through the active and the convalescent periods, the laboratory tests serve as valuable aids in gauging recovery. The determination of the quantitative blood bilirubin or the icterus index is perhaps the most important single determination. The latter ranges between 25 and 60 in the majority of cases. It usually returns to normal in twenty to thirty days but variations in its level and duration are to be expected. The quantitative van den Bergh determination is a desirable test when facilities for its use are available. A positive methylene blue reaction usually parallels the prompt direct van den Bergh test, thus becoming positive in the pre-icteric stage and persisting through the first two-thirds of the icteric period. The cephalin-cholesterol flocculation test is strongly positive from the early icteric stage in 98 per cent of the patients and often parallels the return of the icteric index to normal by becoming negative in fourteen to forty-five days. Liver biopsies suggest the possibility that the cephalin-cholesterol-flocculation test parallels the acute parenchymal changes in the liver. The serum proteins are generally elevated be-

cause the serum globulin fraction is increased from 1 to 4 Gm. per 100 cc. The bromsulfalein index contributes little information in the presence of icterus but it is the best single test late in convalescence when it should be 3 per cent or less in forty-five minutes before the patient is allowed to assume full activity. The leukocyte count is normal or decreased (7,000 to 3,500) with a relative lymphocytosis which tends to recover with the return of the icterus index to normal (fig. 2). The sedimentation rate is slowed in the presence of an elevated blood bilirubin and a sedimentation rate over 20 mm. indicates that a search should be made for the presence of a complication of some other disease or infection. If none is found, the incomplete recovery from hepatitis should be considered.

HEPATITIS WITHOUT JAUNDICE

The history and physical observations, liver function studies, and liver biopsy specimens show that infectious hepatitis may and does exist without the patient ever becoming jaundiced. This apparently is caused by the disease being milder so that the blood bilirubin does not remain high enough over a sufficiently long period of time for the tissues to become saturated and acquire the icteric appearance. Experience indicates that such cases are identical with those in which jaundice appears, but the course and laboratory results suggest that in the former the course is milder in every way except that debility may be as severe and relapses may be more frequent because the true nature of the illness is not suspected or treated in the absence of jaundice.

The relation of icteric and nonicteric cases was shown in the hepatitis following injection of a yellow fever vaccine in the United States, where the men who became ill after receiving similar lots at the same time were studied; those without jaundice were two and one-half times the number that actually became icteric.[2] Although it is difficult and less important to pick up all nonicteric patients with hepatitis who are able to carry on their daily duties, it is important to know that the mild form where jaundice never appears may be experienced because of the epidemiology of infectious hepatitis and for the proper care of patients with it. Patients with doubtful diagnoses will develop symptoms, enlargement and tenderness of the liver, together with aggravation of bromsulfalein retention or elevation of the blood bilirubin if subjected to daily increasing exercises or games of jogging or jolting nature which are helpful diagnostic aids at such times.[3]

CHRONIC HEPATITIS

The term "chronic hepatitis," as opposed to the acute,[3] has been applied to those cases in which patients have failed to recover within a period of four to six months because they are given to prolonged periods of recurrent symptoms, physical manifestations, and/or abnormal liver function tests. They have been unable to tolerate ordinary physical activities and they may suffer relapses to such an extent either in or after leaving the hospital that jaundice may appear for the second or third time. The greatest number of chronic and relapsing patients are derived from those who were never obviously jaundiced or hospitalized in the initial episode or were permitted to remain at work or to return to duty before true recovery had been established. Relapses among those patients previously having infectious hepatitis are often caused by intercurrent infections, particularly malaria, respiratory infections, enteritis, and surgical procedures. Such patients have not done well and approximately 75 per cent of relapse cases will seek further care for weakness, fatty indigestion, chronic diarrheas, irritable bowel, or other seeming psychosomatic disturbances.

A tender liver with symptoms of abdominal distress, right upper quadrant aching, and indigestion which shows an aggravation of symptoms, size of the liver, and/or liver function tests have been regarded as having an active bearing on the liver function and they should be given the advantage of the treatment of absolute rest and diet. Improvement of the patient and his liver function tests under these conditions establish the diagnosis of some form of hepatitis. It is my experience that if one has a chronic hepatitis, it is better to recognize it as soon as possible and institute adequate rest and a nutritious diet at once if recovery is to be expected within three to six months.

TREATMENT

The treatment of hepatitis has undergone revision during the past few years, in that the commonly prescribed high carbohydrate —low fat diet often results in a caloric intake of 2,000 or less calories per day and an inadequate intake of protein. This is true, in part, because the exclusion of fat takes with it much of the available accompanying protein. Special large scale nutritional studies in Italy indicated that patients were in great need of additional protein for liver repair and rehabilitation. When powdered skim milk and certain lean cuts of beef were added, it was clearly demonstrated that the course of hepatitis and the period of convalescence were both shortened, resulting in

a sharp increase in the percentage of patients returned to duty and in a shorter period of time.[1a, 2]

Briefly, this diet consisted of protein, 225 Gm.; fat, 50 to 70 Gm.; and carbohydrates, 400 Gm. The high protein content was made available by giving 200 Gm. of powdered skim milk in a quart of water (four glasses) daily to each patient, along with the two servings of lean fresh beef. It has been found that whenever adequate protein substance, notably fresh meat, was available, the patients would voluntarily eat large quantities of carbohydrates. Formerly, it was difficult to get them to ingest rice, beans, potatoes, or macaroni regularly or in sufficient quantities to raise the carbohydrate intake much over 350 Gm. per day. With the availability of adequate protein substance, which was low in fat, the carbohydrate intake resulted in weight gains of 1 to 3 pounds per week, as contrasted to the commonly experienced weight loss while taking the conventional high carbohydrate-low fat diet. Fresh eggs and fresh butter were tolerated without ill effect, as Turner and others[18] and Hoagland and Shank[11] have reported. The vitamin adjuncts were not shown to be of value but certain experimental evidence suggest polyvitamin therapy. During the early hours of the disease, when nausea and vomiting are encountered, the generous use of intravenous saline solution has often resulted in painful enlargement of the liver with an aggravation of the jaundice so that the giving of intravenous saline solution of more than 1 liter is discouraged. Early infusion of plasma to those who are nauseated and vomiting, and early tolerance of powdered skim milk solution (50 Gm. in a glass of water) at a very early period secures the patient's fluid balance and nutrition.

It is important to note that skim milk contains 3.5 per cent methionine and other readily assimilable proteins so that if amino acids are necessary for the maintenance and repair of the liver cell, it is an ideal, inexpensive, generally available therapeutic substance. Plain skim milk or buttermilk are valuable therapeutic items well-tolerated and retained in the acute stage when ordinary foods or juices are vomited.

CONVALESCENT AND AMBULATORY PERIODS

During convalescence the patient usually feels well and becomes restless. Experience indicates that after approximately three to four weeks of bed rest, the following criteria should be met before permitting the patient to become ambulatory:

1. Bilirubin or icterus index normal for at least one week and the prompt direct qualitative van den Bergh test negative for a similar period.
2. Absence of symptoms, notably anorexia and lassitude.
3. Essentially normal sized and nontender liver.
4. The bromsulfalein retentions under 3 per cent. It is preferable that the alkaline phosphatase be under 4 Bodansky units and the cephalin-cholesterol flocculation test be negative. Caution should be exercised during the early ambulatory period to watch for evidence of relapse as indicated by.
   a. Symptoms of anorexia, nausea, or undue right upper quadrant distress.
   b. Enlargement and increased tenderness of the liver.
   c. Return of positive prompt direct qualitative van den Bergh and positive methylene blue reactions.
   d. Sharp retention of bromsulfalein 20 to 90 per cent.

Patients who have relapses are usually without icterus and the relapse may occur spontaneously at the fifth to tenth week of the disease. Such patients require two to four months additional bed rest and dietary management to regain their former well-being and body weight. A few cases appear to become chronic in that many months of ill-being, failure to gain weight, and multiple symptoms referable to the musculoskeletal and digestive systems may follow. Liver biopsies are indicated in doubtful cases and the periportal areas should be studied for abnormalities and round cell infiltration.

PROGNOSIS

It is believed the average young adult with an icterus index under 30 may expect to be quite recovered in forty days while persons with an icterus index over 75 usually require 90 to 180 days. Complete recovery with physical ability to carry on strenuous labor usually occurs in 95 per cent of adults suffering from infectious hepatitis in 100 to 200 days.

Delayed recovery, recurrent, or chronic cases make up the remaining 5 per cent. These patients are often incorrectly diagnosed as neurotics, problems of irritable colon or functional bowel, or neurocirculatory asthenia. Their recognition depends upon an awareness of chronic latent hepatitis and the ultimate outcome is not yet known, but bed rest, high protein-low fat diet, and reassurance appear to be highly effective.

The incidence of nonalcoholic cirrhosis in young adults recently observed in Syria and Palestine was attributed to infectious hep-

atitis by able physicians at the Universities of Beirut and Jerusalem. The question of subsequent cirrhosis of the liver following infectious hepatitis in the American, Brazilian, and Canadian Expeditionary Forces will be answered only by continued observation, function tests, and further biopsies of the liver.

SUMMARY

The ideal management of infectious hepatitis consists of the following four cardinal points:

1. Early suspicion and recognition of the disease.
2. Absolute bed rest and a liberal diet high in protein for four or more weeks.
3. Proper criteria of adequate convalescence and a carefully supervised rehabilitation.
4. Follow-up observations on physical status and liver function studies to ascertain complete recovery.
5. Patients with long continued symptoms often profit by laparoscopic biopsy of the liver for diagnosis and treatment or reassurance, depending upon the histology.

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PRINCIPLES OF RECONSTRUCTION OF DEFECTS ABOUT THE FACE

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In planning the repair of deformities about the face the surgeon must approach the subject from two viewpoints. The first is an objective analysis of the defect in terms of functional and cosmetic impairment; the second, a consideration of the patient himself in relation to his deformity. In some cases it is obvious that lengthy restorative operative procedures should not be attempted at all, as, for example, in elderly persons with a large defect following removal of an extensive malignancy in whom an artificial prosthetic appliance provides a fairly adequate solution of the problem. Such appliances are also recommended in young persons for whom plastic surgery has as yet little to offer, as in the case of traumatic loss of both upper and lower eyelids. At the other extreme are many patients whose facial defects are either minimal or nonexistent, and here it is essential to study the patient's basic personality in order to arrive at a wise decision as to the advisability of operation. Most spectacular and gratifying results are often obtained in cases where the patient suffers from feelings of inferiority stemming directly from a mild deformity such as a receding chin or a small depressed scar on the face. But even the most perfect profile may seem a dismal failure to a patient who blames a crooked nose for an unsatisfactory home life, which is actually the result of an emotional immaturity no amount of surgery could ever influence favorably.

Reconstructive procedures must, of necessity, be tailor-made to fit the needs of the individual patient. The ultimate aim of surgery is the restoration of normal appearance along with relief of disturbance of function, and the first step is an accurate assay of the size and character of the defect. Both kind and amount of tissue loss must be ascertained and the availability of suitable tissue for repair must be considered before decisions can be made as to operative technique. It is essential as a matter of record and for preoperative study of the patient to have full-view, profile, and angle-view un-

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touched photographs. At times drawings and face moulages are of benefit in planning plastic procedures, and roentgenograms should of course be at hand in every instance where fractures of the facial bones have occurred.

The patient's general condition must be carefully determined. It is a well known fact that healing processes are impaired in underweight and debilitated patients, and plastic surgery especially should be delayed until the serum protein is satisfactory and red cell count and hemoglobin are restored to normal levels with the use of whole blood and plasma as required. The administration of amino acids is of particular value in patients with extensive burns and other conditions associated with weight loss and undernutrition.

It is well to record and outline in advance for each patient the proposed stages of plastic repair and to include a time schedule of length of hospitalization and approximate interval between operative procedures if several are required. A note should be made of probable functional and cosmetic outcome and the patient should be advised what his ultimate prospects will be.

Among the common superficial defects encountered about the face are depressed, adherent scars and distortion of the features from scarring. The more severe defects vary from loss of soft tissue only to involvement of the oral cavity and sinuses and massive avulsion deformities with loss of cartilage and bone in addition to the soft tissues.

In the achievement of good cosmetic results, no matter what type of defect is present, particular attention must be given to the restoration of normal facial contour, profile, and symmetry, since these are responsible for the patient's gross appearance. At the same time every effort should be made to avoid scar contraction, and scarring itself must be reduced to a minimum. Grafts and flaps, when used, must approximate as nearly as possible the normal texture, thickness, and color of the face. Proper proportion of upper and lower lips and a smooth, noninterrupted mucocutaneous border are extremely important in work about the lower face and mouth.

The most important general technique of plastic repair is the rearrangement of existing tissues and includes all operative procedures in which transplants are not required. The simplest procedure is excision of a scar, undermining of the surrounding tissue, and careful approximation of the layers, using staggered suture lines if necessary to follow the normal lines of the face. This is applicable to wide, depressed, and adherent scars where the tissue loss is minimal. For the relief of tension or where contractures have occurred from burns or scars, Z-plasties, advancement, or rotational flaps are employed. Wide surface defects of the malar region and forehead not close to the commissures of the eye or mouth may be remedied by the process of multiple excision. Here small portions of the scar are excised in stages with ample time between operations for subsidence of reactions and relaxation of the skin. Because of the enormous elasticity of the face, a scar may thus be pulled bit by bit to final obliteration and in some instances into a normal line or under the hairline where it becomes unnoticeable (fig. 3, 4, and 9).

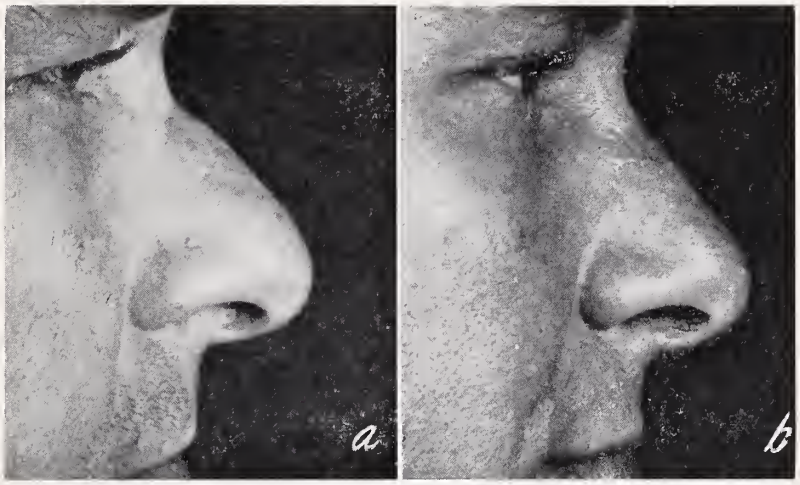

FIG. 1a. Deformity of the nose secondary to shell fragment wound.
b. Reconstruction by preserved cartilage graft and moderate shortening of the nose to get skin coverage.

Whenever the deformity may be relieved without the use of flaps or grafts, the cosmetic results are better since transplanted tissue never resembles its surroundings perfectly in texture and pigmentation.[6] Brown, Byars, and their associates[5] have advocated the introduction of pigment with tattooing apparatus to provide better blending with the adjacent tissues. This is most successful where there is a dead-white or yellowish appearance of the flap or graft and for smoothing out the vermilion border.

Split skin grafts are of inestimable value

FIG. 2a. Deformity of nose caused by avulsion wound with loss of anterior two-thirds of left ala.

b. Four days postoperative photograph showing viable composite free graft which was taken from the ear.

c. Photograph ten days later.

in covering large surface defects. Except in extreme instances, however, their usefulness is limited in spite of simplicity of application and ease of take because they undergo considerable contraction, frequently present a wrinkled appearance and always show a difference in color. They may be used, however, to serve as a temporary dressing to allow for all tissue reaction to subside until more satisfactory procedures can be attempted.

Epithelial inlay grafts using thick split skin are employed chiefly to replace mucosa of the mouth, nose, external auditory canal, and occasionally the conjunctival sac. They are used in the mouth to relieve obliteration of the labio-alveolar and buccal sulci in order that artificial dentures may be worn and to produce an epithelial lined cavity for the support of a permanent intra-oral prosthetic appliance where the loss of the alveolar process and maxilla produces marked facial deformity. Atresia of the nostril or external auditory canal can be corrected by this means. In deformities of the eye socket following traumatic enucleation mucous membrane grafts are more frequently applied by this method; when all the conjunctiva is destroyed, however, skin may be used.

Full-thickness skin grafts are employed to cover areas in which there has been loss of skin and a smooth, supple, elastic surface is required. Small grafts are taken either from the post-aural space or from the supraclavicular area. Although these grafts give an excellent color match, they offer the greatest risk of all transplants so far as successful take is concerned, calling for careful prep-

FIG. 3a. Deformity of nose and upper lid secondary to shell fragment wound. There was considerable tissue loss in the region of the right ala and both nostrils were practically obliterated.

b. Lateral view showing loss of nasal bridge.

c. Photograph following repair. Both nostrils have been opened for normal airway by skin grafts. The loss of tissue over the right side of the nose has been replaced by pedicle skin.

d. Profile after repair. Contour improved by preserved cartilage grafts.

eration of the recipient area, delicate operative technique, definite requirements of pressure, and absolute immobilization. Full thickness grafts may be taken from the scalp for reconstruction of eyebrows but must be narrow to maintain their hair bearing character (fig. 7).

In avulsion deformities where supportive structures as well as cover have been lost, flaps containing skin, subcutaneous tissue, and fat are required to replace the loss. They are usually employed for major rhinoplastic procedures and full thickness loss of the cheek, lips, or chin. For small defects, collar pedicles are made in the supraclavicular region where the skin most nearly matches the color and texture of the face. For larger areas, thoracic flaps are employed. Some of these must be delayed many times prior to their transfer.[1]

Derma-fat grafts are used to restore contour where no additional supportive structure is necessary (fig. 6). Derma is of value chiefly for the relief of small depressions.

Fascia grafts may be used for correction of small depressions but are valuable chiefly for relief of ptosis of the eyelids or for sagging of the face in facial paralysis.

Cartilage is employed for defects of the forehead and bony prominences, for elevation of the eye following dropping of the whole malar bone, and for use in reconstruction of the contour of the nose and ear. Preserved cartilage has been found to be a satisfactory agent for this purpose (fig. 1, 3, 8, and 9).

Brown and Cannon[3] have recently reported the use of composite free grafts of skin and cartilage from the ear for repair of defects of the ala and columella. A similar repair is shown in figure 2.

Bone grafts are generally taken from the ilium and are used chiefly for bone loss in the mandible, occasionally in the maxilla. Although small amounts of loss around the angles of the jaw can be compensated for as a rule by shifting forward of the angle, in the body and symphysis of the mandible, even minimal loss of bone produces severe malocclusion. Excellent results have been obtained with the use of pure cancellous bone which provides for rapid and firm union[2] (fig. 4 and 5). Immobilization is maintained almost entirely by the use of mechanical appliances. Before bone grafts may be attempted there must be a preliminary period of from three to six months after subsidence of inflammatory reaction and extrusion of sequestra to allow for softening of the overlying cover. During this period, the fragments may be maintained in position by cast metal splints on the teeth. Before bone graft

FIG. 4a. Deformity produced by shell fragment wound. In addition to the soft tissue injury there was a 3 cm. gap in the anterior half of the left mandible.
b. Repair by excision of scar and closure in layers with Z-plasty. A cancellous bone graft was placed in the mandible and firm bony union was obtained.

FIG. 5a. Roentgenogram revealing loss of left angle and posterior half left body of the mandible secondary to rifle bullet wound.
b. Roentgenogram following repair with onlay-inlay graft of pure cancellous bone. Soft tissue repair was carried out prior to the bone graft.

FIG. 6a. Deformity of the face secondary to avulsion wound produced by rifle grenade fragment.
b. At operation the scar was excised and the surrounding skin thoroughly undermined. The depression was filled with a free derma-fat graft and the skin closed in layers.
c. Final result.

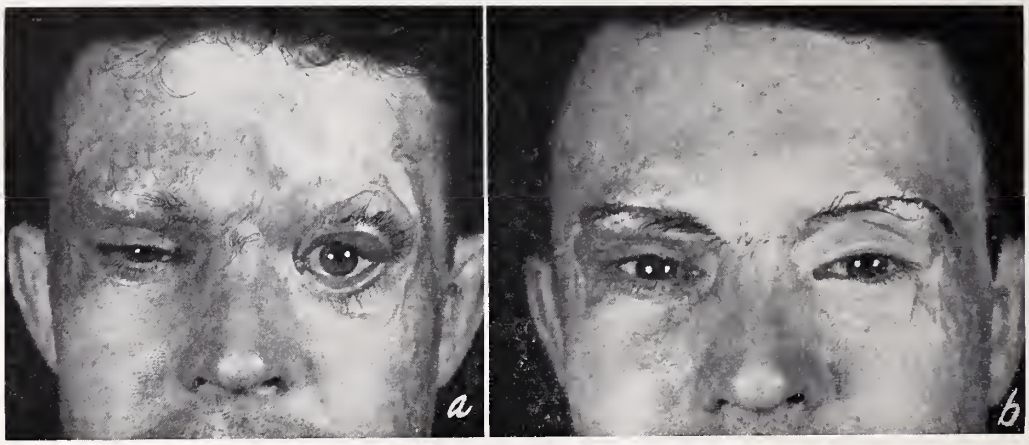

FIG. 7a. Ectropion upper and lower eyelids on left, loss of both eyebrows and extensive scarring of forehead secondary to severe burn incurred when plane was shot down.
b. Eyelids repaired by full-thickness grafts from post-aural regions. The forehead is covered by a large one-piece split graft and eyebrows are free full-thickness scalp grafts.

procedures are attempted, the soft tissue deformity must be corrected. For large avulsion defects, pedicle flaps from the thorax must be employed to give adequate coverage; less severe cicatrices may be treated by rearrangement of the existing tissues.

In discussing the principles of repair of facial deformities, it might not be amiss to add a word on the principles of their prevention. While plastic surgery since World War I has stood on its own feet as a specialty, nevertheless, it holds jurisdiction over no tissues which are not also claimed by other branches of surgery. As a matter of fact, most acute trauma of the face is first seen by the general surgeon, and there is an unfortunate tendency to sew things up quickly and let the plastic surgeon undo the damage later if possible. Careless and faulty approximation of the layers of the skin cannot be too heartily condemned, and the use of coarse suture mate-

FIG. 8a. Loss of lower half of left ear secondary to avulsion wound produced by shell fragment.
b. Repair utilizing a post-aural skin flap and preserved cartilage graft. The defect in the post-aural area is covered by split skin graft.

rial with wide "bites" is an inexcusably frequent practice. Undermining of surrounding skin to provide for relaxation in closure is a safe and easy procedure, and where lacerations occur across the normal lines of the face, a staggered suture line prevents scar contracture and distortion. The deep structures must be approximated as well as the skin. Pressure dressings are imperative to prevent postoperative edema and to obtain healing with a minimum of scarring. In the treatment of acute burns, carefully applied pressure dressings are of inestimable value. Operative incisions about the face should be made wherever possible along the normal skin and shadow lines.

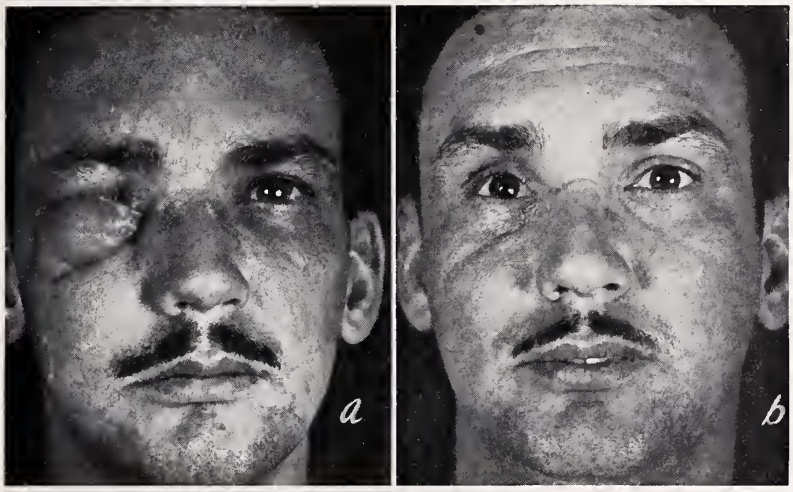

FIG. 9a. Deformity produced by shell fragment wound.
b. Photograph after repair. The scar tissue was excised and the wound reproduced prior to closure in proper layers. A plastic prosthesis is in the eye socket. The floor of the socket was raised by the use of a preserved cartilage transplant.

In conclusion, it may be emphasized that the planning of reconstructive procedures about the face should be based upon knowledge of the personality and general physical condition of the patient, a careful analysis of the defect in terms of cosmetic and functional impairment, an estimate of ultimate results to be achieved, and a selection of plastic technique to fit the needs of the individual case. A well organized and recorded plan of procedure is as essential to the surgeon as is an architect's blueprint.

ABSTRACT OF DISCUSSION

Dr. H. L. D. Kirkham, Houston: There is so much important and valuable material in this paper that it is almost impossible to discuss adequately the highlights in the allotted time, and a discussion could only emphasize the facts brought out rather than add to this very excellent paper.

It can be estimated that about 60 per cent of the ultimate success of any major plastic procedure depends upon the careful over-all planning that has been made in the individual case. The routine adopted at the San Diego Plastic Center was to have each major case gone over by each member of the staff, and each one would submit his suggestion for the over-all plan. Each suggestion was then discussed by the staff as a whole and from these suggestions the best plan was adopted. In addition an alternate plan was also recorded. In this way every member of the staff knew the plan for each case, making it less important who did a particular stage or whether or not one or more of the staff was transferred.

The outstanding difference between plastic repair of the face in World War II and World War I is that present day repair is accomplished by the use and rearrangement of existing tissues, together with the application of Z-plasties and the principles of multiple excision, rather than the use of large flaps carried from distant parts. When a large flap is used, it is done as a matter of expediency and necessity rather than choice, and frequently by a series of Z-plasties and multiple excision the graft covering can be moved to a more distant and inconspicuous location. So important is over-all planning that in training Army surgeons sent for short term instruction the only procedures that were stressed were the principles and application of the Z-plasty and the use of the thick split graft, preferably without the use of the dermatone. It was felt that any measures beyond this should be cared for in a plastic center and not attempted by the general surgeon in the field.

Dr. Blocker has mentioned the recent report of Brown and Cannon in the use of composite free grafts of skin and cartilage from the ear for ala repair. For the sake of the record I would mention that this operation and principle was first used by Gillies five or six years ago. In the early management of acute trauma of the face with loss of tissue extending into a cavity such as the cheek, the ultimate plastic repair is made much simpler if those parts which belong together are brought together, and the lining of the cavity is sutured to the skin covering. This eliminates the formation of much scar tissue which would later have to be removed and at the same time makes available more lining in the ultimate reconstruction.

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Department of Surgery, University of Texas School of Medicine.

Although vaccination against tuberculosis with BCG (Bacillus Calmette Guerin) has never been unanimously accepted, there is increasing evidence that the procedure is of value, particularly in areas where tuberculosis is associated with a high mortality.—J. D. Wassersug, M. D., New England J. Med., Aug. 15, 1946.

RESTORATION OF THE HAND

J. R. COCHRAN, M. D.
FORT WORTH, TEXAS

Surgery of the hand has probably been the most neglected field in all of surgery, and the lack of capable hand surgeons was brought out very clearly in the war just ended. The Army was faced with the problem of reconstructing thousands of hands, and the influx was so great that hand centers were established in this country, one to every service command.

Reconstruction of the hand requires special technique together with a correlation of plastic, neurologic, and orthopedic surgery. One must be prepared to perform any of these procedures to insure a good functional result.

At William Beaumont General Hospital 1,400 cases were under our observation and treatment, and practically every type of injured hand was encountered, the majority of which needed multiple operative procedures to produce a useful hand.

In injuries of the hand[1] an examination should include an evaluation in orderly sequence of damage to skin, bones and joints, tendons, nerves, and blood vessels.

In open wounds one should always be able to ascertain what damage has been done to important tendons and nerves.

Tendons should be examined as follows:

1. For the long flexor or extensor tendons of the thumb the action of the distal joints should be observed.

2. For the long extensor tendons of the fingers the dropped proximal joints should be observed.

3. For the abductor pollicus longus the forward position of the thenar eminence, the weakness on pinching, and the dropped thumb arch should be noted.

4. For the flexor digitorum profundi the loss of flexion of the distal joints should be ascertained.

5. For the lumbricales or interossei the loss of lateral finger motion, of extension of the distal two joints, or of flexion of the proximal joints and simultaneously extension of the distal two, are the significant findings.

Nerves should be examined as follows:

Median—Opposition of the thumb.

Radial—Extension of fingers.

Ulnar—1. Inability of finger spread.
2. Loss of pinch with inability to make an O.
3. Inability to scrape thumb across fingers and palm.
4. Inability to flex fingers at proximal joints and simultaneously extend the other two.

Among the general principles of treatment of acute injuries are (1) the use of general anesthesia; (2) use of a tourniquet; (3) primary repair and closure within six hours; (4) debridement of devitalized tissues; (5) covering of all important structures with split thickness or free full thickness grafts; (6) closure of the wound when possible; (7) reduction of foreign bodies to a minimum; (8) use of plastic principles in enlarging the wound or making exploratory incisions, such as not making T scars, but rather prolonging the ends of incisions or making new incisions, and instead of crossing flexion creases at right angles, using midlateral incisions; (9) suture of severed nerves together with one wire suture, doing classical repair three weeks later; (10) reduction of dislocated joints and irrigation and closure of open joints; (11) repair of tendons only with proper facilities and never suture of old (six to eight hours) or dirty wounds; and (12) use of such chemotherapy as penicillin and sulfa drugs which are of value systemically but not locally.

Postoperative treatment should include moderate pressure dressing, with elevation. The limb should be checked in twenty-four hours for edema and circulation. Circulation should not be interfered with by tight closures, tight dressings, or tight casts.

In reconstructive surgery no repair should be made until four months following healing of the original injury. The procedures then include excision of cicatrix with application of skin graft, followed by attention to bone, joints, tendons, and nerves.

Split thickness grafts should be used over granulation tissues. Free full thickness grafts may be used over small areas, or may be used over larger areas as sliding grafts. Pedicle grafts or tube pedicle grafts from the abdomen should be used where further surgery is necessary at a later date, and where good covering is essential.

In bone and joint repair Kirschner wires should be used for approximation of fragments. Capsulotomy or capsulectomy is suitable for ankylosis of proximal joints without bone destruction. Arthroplasty should be used if bone destruction is present.

Iris forceps and iris scissors are helpful in nerve repair. Eye needles with 7-0 silk should be used, placing three sutures posteriorly and three anteriorly. The funiculi should be matched as accurately as possible. The nerve sheath only should be sutured.

Read before the Section on Surgery, State Medical Association of Texas, Galveston, May 7, 1946.

If the tissues are soft and pliable, and fairly normal, tendon repair should yield excellent results, providing that it is done in conformance with the many principles and with adherence to tiny details. With the correct technique, tendon grafts often give perfect results. Before evaluating what can be accomplished one must consider the amount of cicatrix present, state of nutrition of the hand, type of person, and what procedures were used. Certain tendons give better results than others. Perfect success may be expected in tendons that move the wrist and in extensor pollicus longus and abductor pollicus longus tendons. Next best results are secured when the extensors and flexors of the fingers are repaired in the forearm, the digital extensors on the dorsum of the hand, and the long flexor tendons of the thumb, followed by tendon repairs in the palm. Extensors and flexors within the finger are the most difficult to repair. Most difficult of all are the flexor tendons from the annular tendon sheaths over the metacarpal head to just past the middle joint in the finger, where they pass through the narrow firm tunnel.

Certain principles must be adhered to in repairing tendons to minimize the formation of adhesions. These principles include scrupulous asepsis, atraumatic technique with handling of tissues reduced to a minimum, use of tiny rubber tissue drains, pressure dressings, proper splinting, and elevation.

The object in suturing, of course, is to suture the ends of the severed tendons together until physiologic union occurs. This requires three weeks. Suture material as a foreign body should be reduced to a minimum. The suture should be braided or spliced into a length of tendon. A core suture is preferable to a surface suture. There are two types of suture: silk suture and the stainless steel removable (pull-out) suture of Bunnell. Only the pull-out suture will be described:

End to End.—Using No. 34 stainless steel wire 1 foot long with a straight needle at each end, the first needle is placed through the tendon 5/8 inch from its end. It is then passed back and forth through the tendon. Before starting with the second needle a 7 inch piece of similar wire is laid across the suture to be used as a pull-out stitch. The second needle then passes back and forth through the tendon to emerge from the distal end as did the first needle. The first needle passes through the tendon four times, the second three times. The two ends of the tendon are then drawn taut as is the pull-out suture. Both ends of the pull-out suture are then threaded on a curved needle, passed on up the tendon sheath, out through the skin, and anchored over a button or left free. The two suture ends are then threaded by their needles longitudinally down the center of the distal part of the tendon for an inch or more, and diagonally out through the skin, and tied over a cross bar, a button, adhesive plaster, or the finger nail.

End to End Suture at a Distance.—The object of this is to have the suture in the tendon remote from the tendon juncture so as to minimize the tissue reaction of the latter. This suture is placed exactly as the end to end, but at a distance proximal to the juncture, and is then passed down the tendon sheath, out through the skin, and anchored at such tension that the tendon ends will be approximated. These ends are then attached to each other with a simple double right angle stitch of the finest blood vessel silk, merely for approximation. This type of suture is advisable when the tendon juncture is in a narrow tunnel, such as in a finger.

Tendon to Bone.—In fastening a tendon to bone a simple method is first to chip up an osteoperiosteal flap from the near surface of the bone, then to drill the bone here and pass a straight needle with the two tendon suture ends through the hole in the bone and out the skin on the opposite side of the limb.

The most difficult tendons of all to repair are the flexor tendons in a finger which have been severed somewhere between the middle joint and head of the metacarpal, which, incidentally, is the most frequent site. When this injury occurs, one cannot join the tendons by suture with success, as the juncture will become adherent in the narrow fixed channel and will not slip. It is better to remove the tendons entirely and graft in a new tendon smooth throughout its entire length. Suturing is then done in the palm and at the distal phalanx. Usually the tendon of the sublimus to the same finger is used, withdrawing it through a short transverse incision in the forearm. One flexor tendon must suffice; if two are allowed to remain they will become adherent to one another and thus act on the middle joint alone and not on the distal one. Therefore, the sublimus tendon is removed, severing it opposite the midjoint where it is in the form of two flat ribbons, one on each side of the profundus tendon. If the stubs of this tendon are left too long they will reach out and attach themselves to the proximal phalanx and produce a flexion contracture of the middle joint. If they are left too short, the middle finger joint may hyperextend. If severed in the palm or base of a finger, the end of the distal portion will pro-

liferate, attach, and contract, producing a flexion contracture of the finger.

CONCLUSION

As in World War I, in which plastic surgery really had its inception, World War II has brought attention to another specialty, that of surgery of the hand. It has been stated many times by authorities that the latter has advanced more than any other branch of surgery, and there now has been developed the American Association of Hand Surgeons for which certification will be obtained as for any other specialty.

With the knowledge obtained by examining and treating many hundreds of hands, under the guidance of Dr. Sterling Bunnell, it can be definitely stated that restoration of the hand is possible, and it is no longer necessary for hands to be useless because of improper treatment. Severely mutilated and mangled hands can often be restored to useful hands by a combination of a knowledge of basic fundamental surgical principles, plus that of plastic, orthopedic, and neurologic surgery.

In this paper is given merely a sketch outline of some of the basic fundamentals, namely:

1. Evaluation of the hand by examination.
2. The physical findings present with injuries to tendons and nerves.
3. General principles of treatment of acute injuries.
4. General principles of postoperative treatment.
5. General principles of treatment in reconstruction.
6. Evaluation of results of tendon repair.
7. Technique of repairing tendons, with special emphasis on the removable stainless steel wire suture of Bunnell.
8. Description of proper repair of severed flexor tendons over the proximal phalanx of a finger.

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Medical Arts Bldg.

ABSTRACT OF DISCUSSION

Dr. Leslie Sadler, Waco: The restoration of the hand should begin with the prophylaxis of the extent of the injury during the early phase of treatment. Alan B. Kanavel was the pioneer in this work; Dr. Bunnell has carried the work further and has taught us means of restoration of hand functions which we did not think possible a few years ago. Not all of us can duplicate this work of his because we are not the combination of plastic, general, neurosurgeon, and orthopedic surgeon which he is. Many hands can be restored to more usefulness if we give early and adequate attention to the function soon after injury. Our greatest error is prolonged immobilization.

Dr. T. G. Blocker, Jr., Galveston: It was a pleasure to hear Dr. Cochran's paper on what I consider a very timely subject. There has been no phase of reconstructive surgery that has received greater impetus in World War II than surgery of the hand. This has been the result mainly of the teachings of Dr. Sterling Bunnell, of San Francisco, who during the war and even now has traveled from one plastic center to another inspecting and giving helpful suggestions.

I have had the fortunate experience of having with me at Wakeman General Hospital, Lt. Col. Lot D. Howard, who was trained by Dr. Bunnell and associated with him in civilian life. It has been a pleasure to work with him.

Truly, as Dr. Cochran has pointed out, hand surgery is a specialty per se and though the operative procedures are not too difficult, the exact diagnosis and evaluation of results requires a sound training.

IMMEDIATE REPAIR OF SEVERED TENDONS

WITH END RESULTS IN 140 CASES

HERBERT POYNER, A. B., M. D., F. A. C. S.
HOUSTON, TEXAS

The chief source of livelihood of the average worker is his hands, and anything that results in diminishing their function has economic consequences far beyond the immediate hazard to life. For this reason every effort should be made to recognize and repair promptly injuries to the hands. One of the most serious disabilities of the hand results from the failure to recognize and repair properly a severed tendon. Such injuries are more common than are usually suspected.

The purposes of this paper are to call attention to the frequency of injuries resulting in severed tendons, to describe a simple technique of repair, and to report the end results in 140 consecutive cases where this technique has been employed.

In a total of 18,907 consecutive industrial cases I personally treated there was a total of 212 injuries resulting in one or more severed tendons, a percentage of 1.12. In this group of 212 there were 140 cases involving the tendons of only one finger. It is this group that constitutes the subject of this paper. The remaining 62 cases involved multiple tendons and other associated injuries which will be reported at a later time.

It should be mentioned here that the majority of the following cases involved patients who worked in industries that maintain first aid departments. As a consequence of this, the patients were practically always seen within an hour after injury, which permitted the institution of treatment before the wound was old enough for local infection to develop.

From the Department of Surgery, Baylor University College of Medicine.

Read before Harris County Medical Society, April 17, 1946.
Read before the Section on Surgery, State Medical Association of Texas, Annual Session, May 8, 1946.

Experience has demonstrated that in the absence of shock and other contraindications tendons can be repaired safely within four hours after injury. Most of them can be repaired within six hours, but beyond that time the danger of infection is such that it is usually better not to attempt immediate repair, unless the wound has had prompt and thorough cleansing at the time of the accident.

The diagnosis of a severed tendon is easily made, if one is sufficiently aware of the damage that can be done to tendons through a relatively small wound that otherwise appears innocent. For this reason it is a good custom to test the function of the individual tendons in all cases where a wound has been made over the fingers, palm, wrist, or forearm. In testing for the function of tendons the function of the distal phalanges should be tested independently. One cannot emphasize this point too strongly, because patients are repeatedly observed who have had a seemingly innocent wound sutured, but later it was discovered that they had lost the power of flexion or extension of a finger. It should be borne in mind also that nerve function should be checked at the same time.

Failure to recognize a severed tendon results in a long period of disability before the secondary repair can be attempted and the late repair of tendons has not resulted in as good results as is accomplished with immediate repair. This is because of the formation of dense adhesions, the difficulty of dissection, and, to a considerable extent, the loss of the gliding function of the tendon sheath when repaired late. The proper repair of a severed tendon is a meticulous and time consuming job, but it can be mastered by any one doing a general practice who is willing to observe the necessary care. Injuries to the tendons occurring outside of industrial plants are seen first by physicians engaged in general practice. It is at this time that the repair should be done and for this reason the following technique is described:

If the hand is greasy or covered with greasy dirt, it should be washed first with benzene. Afterward it should be thoroughly scrubbed with soap and a soft brush under a stream of running water for a full ten minutes, in a manner comparable to that employed by a surgeon in preparation of his own hands. The wound is then ready for repair. If one desires, it may be painted with any of the antiseptics except full strength iodine, which apparently causes a definite increase of adhesions about the tendons. If iodine is used, it should be half strength and should be removed immediately with alcohol. The anesthesia may be a general one or a nerve block anesthesia applied at the elbow. The latter in my experience is preferable and is entirely satisfactory, but appears to require a little more experience for its use. A small quantity of 2 per cent novocain is injected into the ulnar, median, and radial nerves; the radial nerve lies half way between the biceps tendon and the external condyle of the humerus and the median nerve lies half way between the medial

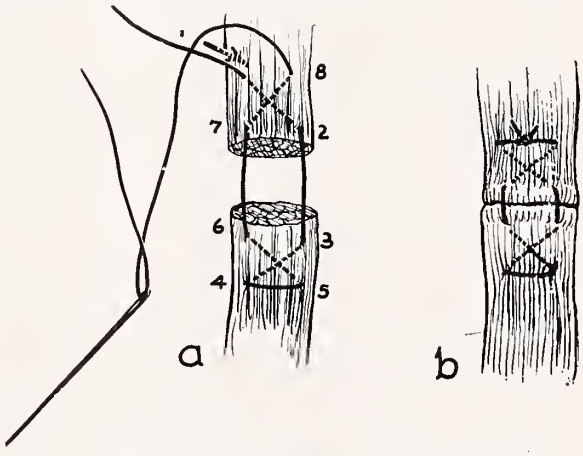

FIG. 1. Diagram showing details of the application of a suture in the repair of tendons.
a. Beginning at *1* the suture is passed through the tendon and brought back to the original surface at *2*. The suture is then passed to each of the numbered points in consecutive order as shown on the diagram, the solid lines indicating the outside, and the dotted lines the inside, suture. When the suture is completed, tension around the enclosed tendon bundles gives an amazingly strong repair. A little practice is usually needed to apply this suture accurately. This practice may be had by suturing the ends of a small cotton cord.
b. Appearance of tendon at completion of the suture.

condyle and the biceps tendon. A small amount of novocain should be deposited in a fanlike area about these nerves. Following the injection of the nerves it is important to inject the subcutaneous tissues by a narrow cuff completely about the elbow, since failure to do this makes it impossible to secure complete anesthesia of the hand. One should wait a full five minutes after injection before beginning the operation; otherwise the patient may experience some pain at the start and will be apprehensive during the remainder of the procedure.

When anesthesia is obtained, the hand is draped; bleeding can be controlled by a blood pressure cuff with adequate inflation. A careful debridement of the wound edges is then done with a very sharp knife, care being taken to remove only a superficial layer of tissue unless the wound is unusually dirty. If the wound is distal to the metacarpophalangeal joint, a small elastic band may be placed about the finger for hemostasis, which is absolutely essential before closing

the wound. I prefer to obtain hemostasis with small hemostats and to tie all bleeding points before proceeding with the operation. The formation of a hematoma will not only increase the danger of infection, but will cause additional adhesions about the tendon. After adequate exposure and complete hemostasis is obtained one is prepared to suture the tendon. It should be pointed out here that the proximal ends of the flexor tendons of the finger always retract .5 to 1.5 inches up the tendon sheath. In making an incision to allow for this retraction care should be taken to avoid placing the incision over the palmar surface, but instead it should be placed on the anterolateral aspect of the finger for the flexors and on the dorsolateral aspect for the extensors. Several authors repeatedly warn against making an incision across the flexion crease. In my opinion this should be avoided when possible, but the frequency of satisfactory healing in the flexion crease suggests that this point has been over emphasized. After careful dissection of the tissues from the tendon sheath, a little experience will show where the proximal ends of the severed tendon have retracted. If this is too far above the original wound in the tendon sheath for the tendon to be reached, it is a good custom to make an incision in the lateral aspect of the sheath at the level to which the end has withdrawn. Then the tendon should be withdrawn and the first half of the suture applied to the proximal ends. These sutures are passed through the eye of a small bent probe, which is passed up through the tendon sheath to the level of the original wound. The distal end of the tendon is secured, the suture applied in like manner, and the tendon ends drawn together and the suture tied using No. 1, 3 pound braided silk suture.

If both the profunda and sublimis tendons have been severed, it is accepted procedure to repair only the profunda tendon. This has seemed to be an unnecessary sacrifice of function and in such cases reported here both of the tendons were repaired at the same time. In so doing the sutures were placed in such a position that the exposed suture material was on the palmar aspect of the sublimis tendon and on the dorsal aspect of the profunda tendon.

The essence of success in the repair of tendons is in the application of the suture, and the details of the application in the reported cases are shown in the accompanying diagram (fig. 1).

It will be noted that after the suture is tied the direction of the traction of the suture is around the bundle of the tendon and not in line with the tendon fibers. Early active motion is thereby permissible, and it prevents the formation or breaks up adhesions about the tendon. In addition, when nerve block anesthesia is used, it permits flexion and extension of the finger to ascertain the restoration of function before the wound is closed. This demonstrates that the function has been restored and aids in securing the patient's coöperation at a later date.

If either extensor or flexor tendons have been torn off the base of the distal phalanx and there is an insufficient amount of the distal portion properly to apply the suture, a very small drill hole can be made in the phalanx and the suture passed through this hole and tied. A few such sutures will pull out, but the majority will result in active function of the distal phalanx. After the tendon is sutured, the wound is closed without any attempt to close the tendon sheath, but the surrounding fat should be brought over the tendon. A large dressing is applied to the extremity with sufficient firmness for hemostasis, and it should not be too tight or uncomfortable. The hand is placed in a sling and the patient is permitted to return home with instructions to keep the hand elevated for the first few hours. The patient is seen the following day and all except the dressing next to the wound is removed and active flexion or extension is observed. This is repeated carefully each day until the wound in the skin has healed. The dressing is then removed and the patient encouraged to move the finger freely. Complete healing requires five to six weeks, and the use of the hand for work, therefore, is not permitted immediately, but active motion is continued as freely as possible. This is contrary to the usual procedure of splinting the finger for three to four weeks and then attempting to break up the adhesions. The time required to break these adhesions after splinting and the failure to secure adequate function is the reason for beginning active motion early. The results obtained by this method seem fully to justify it. At the end of six weeks the patient is encouraged to use his hand at his usual duties and is given such exercises as are indicated to regain the full range of motion. These persons are kept at duty but are observed for as long as three months in order to secure the greatest possible restoration of function.

The distribution of these injuries shows a total of 29 injuries to the flexors, in most of which the flexor sublimis and flexor profundus tendons were severed. Of this group, 14 patients, or 48.2 per cent, showed some residual disability. Of the 111 patients with

injuries to the extensor tendons, 23 or 20.7 per cent showed residual disability. Of the 140 cases, 37, or 26.4 per cent, showed some disability. Any one acquainted with the Texas compensation laws will know that this percentage of disability would definitely have been lower if these had been private patients, but since these estimates of disability were the basis of compensation settlement they are reported without comment.

The particular tendon injury and the results obtained in repair are shown in tables 1 and 2.

TABLE 1.—*Results Obtained in Repair of Injuries to Flexor Tendons.*

Injured Finger	No. Cases	No Disability	Disability
Thumb	5	1	1— 20% of thumb.
			1— 35% of thumb.*
			1— 35% of distal phalanx.
			1— 50% of distal phalanx.
Index	7	4	1— 50% of finger.†
			1— 66% of finger.†
			1— 35% of distal phalanx.
Middle	4	2	1— 50% of finger.‡
			1—100% distal phalanx.§
Ring	1	1	
Little	12	7	2— 10% of finger.
			1— 50% of finger.¶
			1—100% distal phalanx.‖
			1— 10% of hand.¶
Total	29	15	14

*This case was accompanied by a compound, comminuted fracture of the proximal phalanx of the thumb. An associated bone injury with a severed tendon practically always results in some disability.

†These 2 cases were associated with compound fractures of the proximal phalanx.

‡Associated compound fracture of the proximal phalanx.

§This case resulted from failure of the suture caused by local infection and a sloughing out of the tendon suture.

‖Both were associated with compound fractures.

¶This was accompanied by a compound fracture followed by an infection of the tendon sheath. Repair was done eight hours after the injury. The disability was therefore based on the hand rather than the finger. This estimate was made as a result of the scars for incisions and drainage having to be placed over the ulna bursa and is equivalent to a 100 per cent loss of the little finger.

TABLE 2.—*Results Obtained in Repair of Injuries to Extensor Tendons.*

Injured Finger	No. Cases	No Disability	Disability
Thumb	18	14	1— 10% of thumb.
			1— 10% of distal phalanx.
			1— 25% of distal phalanx.
			1—100% distal phalanx.*
Index	33	28	1— 10% of index finger.
			1— 25% of index finger.
			1— 30% of distal phalanx.
			2— 75% distal phalanx.†
Middle	31	23	1— 5% of middle finger.
			1— 15% of middle finger.
			1— 30% of middle finger.
			2— 35% of distal phalanx.
			2— 75% of distal phalanx.
			1—100% distal phalanx.‡
Ring	15	11	1— 10% of ring finger.
			1— 35% of ring finger.
			1—100% of ring finger.§
			1—75% of distal phalanx.
Little	14	12	1— 50% of little finger.‖
			1—100% distal phalanx.¶
Total	111	88	23

*This one was associated with a compound fracture of both the proximal and distal phalanges.

†These 2 cases had no infection and no fracture.

‡This was due to failure of the suture passing through a drill hole.

§This was associated with a compound fracture into the joint, resulting in complete ankylosis of the proximal interphalangeal joint, and associated with immobilizing adhesions of the tendons.

‖This resulted from formation of dense adhesions, which interfered with extension.

¶This one associated with a compound fracture into the joint with no infection.

CONCLUSIONS

1. The technique of repairing severed tendons is described.

2. The end results obtained in 140 cases using this technique are reported in detail.

ABSTRACT OF DISCUSSION

Dr. Walter Stuck, San Antonio: I agree with all that Dr. Poyner has said and can merely emphasize the points which I consider important. In the first place, I am constantly impressed with the number of neglected small wounds on fingers that may have unrecognized accompanying tendon injuries. When the patients complain of inability to move the fingers later, the golden opportunity has passed for a successful primary suture.

The hazards of infection in tendons are similar to those of bone where there is little inherent ability to combat it. Traumatized tendon tissue must be carefully handled and the wound must be thoroughly cleansed if infections and scarring are to be avoided. The obvious point is that the sooner the wound is treated, the less chance there is for infection.

Nerve blocks at the elbow are very useful, I am sure, but most surgeons cannot do them satisfactorily. I use pentothal but, of course, do not have the advantage of directing the patient to move the tendon after suture.

Dr. Poyner has shown excellent results with the relatively short silk suture. I have used fine stainless steel wire to gain early motion but that is purely a matter of personal preference. I cannot see that one is any better than the other. Tantalum wire has been tried but it is not as strong as steel and the wire has a rough surface so that knots cannot be tied as easily. Two years ago, in San Francisco, I watched Sterling Bunnell, the master of all surgeons, place his stay sutures to prevent pull on the tendons and the pull-out loops to remove the wires after the tendons had healed. He gains beautiful results with this method but most surgeons are not so skillful. The simpler suture Dr. Poyner has used so successfully will satisfy most patients unless they are musicians or persons who do fine work with their hands.

A. M. A. CENTENNIAL BROADCASTS

Nationwide broadcasts commemorating the centennial of the founding of the American Medical Association are being presented over the National Broadcasting Company network at 3 o'clock each Saturday afternoon. The twelfth annual series of A. M. A. broadcasts, the current series entitled "Doctors—Then and Now" began December 7. A century of progress in American medicine is being portrayed in each program by a dramatization dealing with historic physicians and events in a particular region of the United States followed by a short talk explaining the present status of medicine in that region.

General hospitals could materially assist in the campaign for the further reduction and possibly the eradication of pulmonary tuberculosis by providing routine radiological examinations of the chests of all patients upon admission. New techniques in this connection have materially reduced the costs of such examinations. As a routine procedure, chest filming has been shown to be of greater value in disclosing abnormal conditions than is true of many other routine diagnostic procedures now generally practiced, such as urinalyses, blood counts, and serological examinations.—Hospital Survey News Letter, Feb., 1946.

MARCUS GUNN PHENOMENON

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In 1883 Marcus Gunn reported a case of congenital ptosis with peculiar associated movements of one lid in a 17 year old girl. This was first noted by the parents soon after birth while the child was nursing. As the child grew, the up and down movement of the left lid was quite noticeable during the act of eating. According to the parents, the movement of the lid, as well as the drooping, seemed to have diminished somewhat during the two or three years prior to the time that Marcus Gunn examined the girl. His examination revealed some facial asymmetry and ptosis to the degree that the left upper lid covered the upper quarter of the pupil. The fold of the left upper lid was oblique as compared with that of the right, which ran parallel to the free border. The left pupil was smaller than the right but all pupillary actions were normal, and no other components of Horner's syndrome were present. Synchronous movement of the upper lids was present with both the upward and downward gaze; however, the upper lid did not rise as high on the left as it did on the right. Closure of the left eye was not as perfect as that of the right. Any attempt at hyperelevation of the left lid was not possible without the aid of the frontalis muscle. This supplementary muscular action at best only slightly diminished the ptosis. Movement of the jaw to the right, action of the external pterygoid muscle, was accompanied by hyperelevation of the left lid, and this extreme elevation was maintained as long as the activating muscle was at work. Protrusion of the jaw also caused the same hyperelevation of the left lid. The greatest excursion in both instances was affected with the downward gaze. Action of the left levator muscle was visible beneath the skin folds when the left external pterygoid muscle was activated with the lids closed. No movement of the eye or pupil was noted during the upward movement of the lid.

These observations, recorded by Gunn and confirmed by a committee of three neurologists and one ophthalmologist, still stand as the essential criterion for the syndrome now named after him. It is commonly referred to as the "jaw winking reflex."

In 1895 Sinclair, in the *Ophthalmological Review*, reviewed cases of unusual associated movements of the eyelids which had occurred since Gunn's first communication in 1883. He divided the cases into four separate groups:

1. Thirteen cases of unilateral congenital ptosis in which the drooping eyelid is raised both when the mouth is open and when the jaw is directed to the opposite side.
2. Thirteen cases of unilateral congenital ptosis in which the drooping eyelid is raised when the jaw is depressed. It is not raised on lateral movement of the jaw.
3. Three cases of unilateral congenital ptosis in which drooping of the eyelid is raised with lateral movement of the jaw but without effect by simply opening the mouth.
4. Four cases in which similarly associated movements of the upper lid with movements of the lower jaw occurred but in which there was no ptosis.

In March, 1936, Francis C. Grant reviewed the literature and found that 100 cases had been reported. A summary and analysis of the cases showed that this phenomenon was not thought to be hereditary although it has been described in father and daughter and also in cousins. Ninety-three per cent were considered congenital. Seven per cent were supposedly acquired. The acquired forms usually had some history of trauma or exposure to extreme cold. Males are more frequently affected than females, and the left eyelid is more commonly implicated than the right. Complete absence of ptosis of both eyelids has been recorded in 7 cases but bilateral ptosis has been noted in only 3 cases. Ptosis usually is slight and incomplete, and in a majority of cases the ptosed eyelid could be voluntarily elevated. The motility of the ipsilateral eye was usually unaffected; however, paralysis of one or more of the extraocular muscles has been observed. Ordinarily the pupils are normal and equal; but when inequality in size occurs, it is the pupil of the affected side which is smaller. Pupillary and corneal reflexes are always present, and the visual acuity is not affected. Fromaget and Brun reported an extraordinary case in which there was a complete congenital ptosis of the right eyelid which could be relieved by opening the mouth in the midline, by moving the jaw forward, backward, or to either side, and by clinching the teeth tightly together; but most amazing of all was that when the subject closed the left eye or the eyelid was pulled down by the examiner, the ptosed right eyelid was promptly opened. Closure of the left lid was necessary to produce this reaction since simply covering the left eye did not cause elevation of the lid.

Cases have been reported in which puffing out the cheeks, as in the act of whistling, produced elevation of the lid. Another case was reported in which swallowing and movement of the larynx caused slight elevation of the lid. Franc D. Ingraham reported a case in

Read before the Section on Eye, Ear, Nose, and Throat, State Medical Association of Texas, Annual Session, Galveston, May 7, 1946.

which the Marcus Gunn phenomenon was present in an epileptic patient who subsequently was subjected to an exploration of the brain, and it was found that the phenomenon could be elicited by cortical stimulation over a rather wide area surrounding the Sylvian fissure. A decortication operation for release of the epileptic seizures did not affect the ptosis of the lid nor the Marcus-Gunn phenomenon.

Grant, who has done considerable work in an effort to determine the pathways of the reflex, reported an unusual case in which the elevation of the lid on lateral movement of the jaw was completely abolished by the instillation of one drop of 1 per cent homatropine in the eye of the affected side.

CASE REPORTS

CASE 1.—The patient was a boy, 3.5 years old, in whom drooping of the right upper lid was noted soon after birth. The delivery was complicated by contusion of the left temporal and frontal area and the left lid. There was closure of the left lid from swelling lasting over a period of five days. Soon after the delivery, the mother noted that there was a peculiar movement of the right upper lid when the child was fed. The mother felt that this was definitely associated with swallowing as much as with movement of the jaws.

The family history was entirely normal except for a variable type of headache which the mother had had since the birth of this child. He had one sister 2 years old who was perfectly normal in every way. The child had not had any unusual diseases; however, his posture was poor. He had a slumping stance with drooping of the right shoulder and a left tilt to the head. Apparently the head tilt was a result of the ptosis of his right lid. There were no skin sensory changes present and no evidence of flushing, sweating, or lacrimation on the right side.

The left eye was perfectly normal in all appearances, and the movements of the lid were normal on this side. With the gaze directed forward, there was a 2 mm. droop of the right upper lid. The lid was raised with the upward gaze, and it fell fairly well with the downward gaze. Forcibly depressing the jaw, clinching the teeth, or swinging the jaw to the left caused hyperelevation of the right upper lid. Elevation to a lesser degree was brought about in the act of swallowing, but no effect was noted when the patient talked. Swinging the jaw to the right did not bring about any apparent change in the elevation of the lid. The pupils were equal and reacted normally to light and accommodation. Dilatation of the pupil was equal on each side with 4 per cent cocaine and 2 per cent homatropine. No effect of the ptosis nor the hyperelevation of the right lid was noted after instillation of homatropine. All associated movements of the eyes were normal, and no evidence of paralysis could be found other than the ptosis of the lid.

CASE 2.—The patient was a 17 year old Mexican boy in whom ptosis and peculiar movement of the right upper lid was noted soon after birth when the baby was nursing. This continued to the same degree as he grew older. There was no family history of nervous disorders, epilepsy, or headache other than moderately severe headache that his mother had at infrequent intervals and occasionally right frontal headaches which the patient experienced rather infrequently. Physical examination was normal other than a small preauricular gland to which the patient himself attached some significance as far as the movement of his eyelid was concerned. The laboratory tests and neurological examinations were normal except for the jaw winking reflex.

Examination of the left eye and lid proved them normal in all respects. Examination of the right eye and lid showed approximately 2 mm. of ptosis with the eyes in the front position. On voluntary effort to elevate the lids, the left upper lid raised about the same amount higher than the right as the degree of ptosis. This occurred both with and without the action of the frontalis. However, the right lid was drawn sharply upward when the mouth was opened forcibly or when the jaw was deviated to the left side either with the mouth closed or open. The elevation of the upper lid, of course, became more evident when the eye was directed in a downward gaze. There was no deviation of the lid when the mouth was forcibly closed unless there was an attempt made to deviate the jaw to the left. Slow passive opening of the jaw did not cause any elevation of the lid but extreme opening in the midline caused a rather marked upswing. Movement of the tongue, larynx, and pharynx had no effect on the lid. Injection of the mandibular branch of the fifth nerve with procaine did not eliminate the action of the levator although it did decrease to a certain extent the elevation which occurred on the various movements as described previously. I do not believe that the innervation of the external pterygoid was completely paralyzed. Four per cent cocaine instilled into each eye resulted in equal dilatation. There previously had not been any disparity in the size of the pupils. Two drops of 2 per cent homatropine were instilled in each eye, and this did not change the amount of ptosis and the pupils dilated equally. There was no diplopia with the red and green glass, and no other evidence of faulty action of any of the extraocular muscles could be observed. Accommodation and convergence were normal.

Grant and others have done considerable experimental as well as clinical research work on this reflex but so far no definite conclusions as to the actual pathways involved have been reached. The original writers seemed to be of the opinion that there was a peripheral nerve anomaly resulting in stimulation to the levator and external pterygoid muscles simultaneously. However, the more recent investigators seem to lean toward the idea of an overflow of impulses centrally. From the neurosurgical standpoint, the efforts to relieve the syndrome have been directed toward elimination of the motor route of the fifth nerve. This has been carried out on different patients, apparently with a certain amount of success and without too much inconvenience as far as mastication is concerned. The procedure seems to be a formidable one since the best results have been obtained by the intracranial approach rather than section of the mandibular branch alone. From the ophthalmologist's standpoint, it would seem to be simpler to eliminate the action of the levator entirely and proceed with some type of ptosis operation, utilizing the superior rectus muscle in raising the lid.

Where movement is slight, these patients probably would best be left alone. However,

considerable embarrassment with resulting personality suppression is afforded a good percentage of cases, more particularly so if the movement is present in talking as well as chewing. This is true in my second case, and the patient sincerely desires to have the movement eliminated, even though the droop of the lid may be increased.

ABSTRACT OF DISCUSSION

Dr. Charles R. Potts, Houston: Dr. Black has added 2 more cases of Gunn's phenomenon to the literature.

If we attempt to discuss the causes we find ourselves in the realm of speculation as the site or sites of the lesion which produces this anomalous innervation have not yet been determined. Cooper in his report in 1934 called attention to the proximity of the third and fifth nucleus and it is easier to understand the cases that are of congenital origin than the ones sometimes following trauma. Neurologists in attempts to locate the lesion have so far been unable to offer definite proof as to the site.

Dr. Spaeth stated that the more marked cases of Gunn's phenomenon should be converted first into a complete ptosis and then one of the various types of ptosis operations performed. I believe the more moderate cases are best left alone. I have enjoyed Dr. Black's presentation and the opportunity of reviewing the case he presented.

Dr. Oscar Marchman, Jr., Dallas: Dr. Black gave a very interesting and enlightening discourse on this neurological phenomenon. I find the subject interesting in that there are several associated types and combinations of anomalous reflexes as brought out by Dr. Black's 2 cases. Lately I have observed a doctor's wife in whom swallowing produced elevation of the right lid. Another patient who had extensive laceration of the face eight years ago has paresis of elevation of the right eye, with forced mastication, the right eye turned down and in.

The etiology of these conditions is also varied:

A. Trauma, where regenerated axis cylinders pass to muscles other than those originally supplied.

B. Developmental defects with a number of cases found in the same family.

1. Overflow of impulses centrally with an unusual relation between the levator portion of the third nerve nucleus and the pterygoid portion of the fifth nucleus. The levator receives less than its normal innervation, resulting in a certain degree of ptosis; at the same time the levator receives some fibers which were intended for the external pterygoid so that when that muscle is put strongly in action, the levator is unintentionally innervated, producing the curious effect described.

2. Disturbance in coördination where the lesion is supranuclear in the posterior longitudinal bundle or the optic thalmus. This nerve fiber bundle serves to connect the visceral reflex center in the thalmus with the motor nucleus of the cranial nerves.

C. Stimulation of cortical foci in the fronto-parietal region.

Dr. Black, closing: I wish to thank Dr. Potts and Dr. Marchman for their interesting discussion of the paper, also Dr. Guyton for calling attention to cases in which he has operated, converting the condition into a complete ptosis and then correcting with one of his various procedures. In spite of the exacting research work that has been done in the past in an effort to locate the site or sites of lesion causing this phenomenon, no definite and positive statement can be made. It is interesting that the neurosurgeons must sever the entire root of the fifth nerve before adequate result can be obtained. I am wondering if this does not in some way point to a definite central anomaly with an overflow of impulses as suggested by Drs. Potts and Marchman and others.

IS MASS SEROLOGY WORTH WHILE?

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For about ten years pathologists have been witnessing, and taking part in, a much publicized campaign against syphilis and other venereal diseases. This crusade has been led by public health agencies and has been characterized throughout by a ritualistic orgy of blood letting which has been called dragnet serology or mass serology. This taking and testing of blood has all too often become an end in itself. This furor has reached its peak in the form of a state law in Alabama requiring every person between the ages of 14 and 50 to have a blood test for syphilis, or be penalized by a fine or jail sentence.

This program has been steam-rollered on the public and the medical profession with little chance for discussion or evaluation. No one, apparently, has taken the time or thought necessary to evaluate the value or cost of such a program. Protests to various phases of the program have been crushed under the weight of a militant bureaucracy running forward in high gear.

It is high time that members of the medical profession, and especially pathologists, take an interest in what is going on, discuss it, and form some opinions on the subject. I am biased in the matter and this discussion is admittedly biased, and purposely so, in order to arouse thought about the matter. The rationale, costs, and results of the program will be discussed in a general way.

There is no purpose in quoting statistics concerning the past or present incidence of syphilis, for many reasons. Before syphilis became a household word, the disease was not diagnosed or reported as accurately as it is today, making for a large error in the older figures, and making it seem that there are now more cases than previously. War usually brings an increase of venereal disease and whether the wartime increase was as much as should be expected is another factor that is almost impossible to put down in black and white. It is certain that the campaign against venereal disease did hold the expected increase in check to some extent.

Chairman's address before the Section on Clinical Pathology, State Medical Association of Texas, Annual Session, Galveston, May 7, 1946.

Treatment has been made more easily available to a great many people, and this, along with the quicker methods of treatment, has no doubt decreased the incidence of syphilis somewhat. No one with all available figures at hand could hope accurately to evaluate the decrease in the disease, but it is plain to see in general that the decrease is not in proportion to the time, money, and effort that have for years been expended. Syphilis is still a major problem and will be for some time to come.

The syphilis campaign can be credited with great advances in the performance of blood tests in laboratories operated by pathologists. Early evaluation studies showed just how poor some of the tests in use actually were and how poor the performance of those tests was. Pathologists have, through the efforts of private and public health laboratories, mainly the latter, found fairly accurate yardsticks with which to measure the sensitivity and specificity of the tests, and they have learned to judge various tests on their merits. They have come to a much better understanding of the significance of blood tests for syphilis, the good points and the bad points. They have found that the tests are not always specific and they have learned at least some of the causes of false positive reactions and the myriad other diseases that can at times interfere with clear-cut serologic tests for syphilis.

Along with this progress in the laboratory diagnosis of syphilis have come other things which should go on the debit side of the ledger. The over-all campaign against syphilis has overstressed the importance of serology and has required directly or indirectly the testing of large groups of people, such as food handlers, draft inductees, and others. These artificial demands for blood testing naturally have overtaxed private laboratories, and in many cases have been an economic burden to the groups of people involved. Public health agencies have then stepped into the gap and offered to fill the need which they themselves have created. In this way public health facilities have been enormously expanded, as has been true in Texas. Since federal funds have in part been used in this expansion of laboratories, it has been necessary to relinquish the idea that public laboratories should serve only indigent persons, since, unlike the state laboratory service, federal services to the public in connection with syphilis control, both as to diagnosis and treatment, are based on the idea that such services should be available without cost to any citizen, rich or poor. This policy is very important to private practioners of pathology. While they have been aided in many ways by public health laboratories, they have sold their birthright to perform private serologic tests for a mess of pottage.

Although pathologists have improved the performance and interpretation of serologic tests in their laboratories, the new knowledge acquired has not been put to adequate use. The general medical profession still has no working understanding of the meaning and uses of the tests for syphilis, or the difficulties involved in performing the tests well. The profession generally does not know yet what is good serologic service and what is not. A 75 cent mail order Wassermann test run by a layman without medical supervision is just as satisfactory to many of the brethren in general practice as the best serologic tests that clinical pathologists can do. The public has been led to believe, directly and indirectly, that any positive test for syphilis indicates a great degree of contagiousness, which of course is totally erroneous. Advances in serological technique will all come to naught unless they are put to use rationally.

The cost of the venereal disease program in money and time has received scant notice or thought. It is too easy to regard services rendered by government agencies as free, but often they are very expensive, and surely must be paid for eventually. The only definite cost accounting I have found was reported from California.[1] In testing members of a labor union there it was found that the cost of finding a previously unknown case of syphilis was $42. Only 28 per cent of those cases discovered were early (under four years duration) and so possibly contagious. So from the standpoint of locating possible sources of infection, the cost was about $125 per case. Certainly some less expensive method could be found.

Someone decided that draft inductees should all be tested, as most of us learned to our sorrow. As will be remembered, in the first years of the draft, men with positive serologic tests were not taken into the Armed Services but were retained in the civilian population where they might or might not receive treatment. All too often they were given treatment until their blood tested negative, at which time a Selective Service clerk would decide that their syphilis was cured sufficiently so that they could serve in the Army. This was admittedly not good medical practice, nor good syphilis control, but that is the way it often worked out.

A study of one group[2] of 5,000 patients thought to have syphilis, but taken into the Army and studied carefully, showed on final

diagnosis that 11.4 per cent were not syphilitic and another 10.56 per cent had no evidence of syphilis although they had had some treatment. There were 1.24 per cent primary, 0.14 per cent secondary, and 48.84 per cent early latent cases in the group. Thus in this group of 5,000 men, an error of 20 per cent false diagnoses were made by means of serologic survey.

In connection with the draftee Wassermann program four copies of each report were made, one for the laboratory files, one for the Draft Board, one for the State Health Department, and one for the United States Public Health Service. It staggers the imagination to try to figure the cost of handling and filing all those reports, and one wonders what purpose was eventually served in compiling all the records. The cost in time, effort, and money of drawing, handling, and testing the blood will never be totaled or recorded. A little mental arithmetic will show that enough blood was drawn to make about 40,000 doses of plasma. All in all the draftee serology program was a very expensive experiment.

As has been mentioned, the advances made in the performance of serologic tests will not be worth while until serology is made to fit into its proper place in the diagnosis of syphilis. The diagnosis of syphilis is not primarily a laboratory procedure, but is a clinical problem in which the laboratory gives confirmation. Pathologists know the limitations of serologic tests and know that the diagnosis of syphilis should not be made on the basis of a single positive or doubtful blood test. They also realize that a positive blood test is not indicative of whether or not a case of syphilis is in a contagious stage. Yet the laws restricting employment of certain groups on the basis of blood tests and the campaigns to have whole communities tested are predicated on the false premise that positive serologic tests indicate a contagious phase of the disease.

Some have no doubt seen renewals of licenses refused by the State Board of Cosmetology on the basis of a 1 plus Kline test, with a negative Kahn and Kolmer test. That a board composed of laymen should on this basis deny employment to a citizen is the height of absurdity and a perversion of justice. Although few if any cases of syphilis have been contracted in grocery stores or restaurants, in many cities and towns health cards for food handlers are issued or denied on the basis of Wassermann tests.

It is my opinion that no group of people should be allowed or denied employment on the basis of the serologic tests at present available, performed and interpreted by nonmedical persons. If it is ever possible to develop a test which will indicate that syphilis is in a contagious stage, and which is 100 per cent sensitive and 100 per cent specific, then and only then should laws be passed making negative blood tests a prerequisite of employment.

The false and doubtful tests which occur in these group surveys present a problem which is almost as great, although including numerically a small group, as any cases of proved syphilis. Many physicians have seen pitiful persons, some of whom never know whether they have syphilis or not, go through months or years of mental torture. Many of these patients are partially treated and the diagnosis is finally so obscured that one can never be sure whether they ever had syphilis or not. Many of these problem cases eventually must be handled by private practitioners and private laboratories because of the need for careful study over a period of time and individual attention to each such case.

Altogether the picture is not as rosy as the crusaders present it; I venture to assert that if the same amount of time, money, and effort had been used economically and sensibly in tracing the sources of infection of each new case of early syphilis found, the disease would be significantly decreased in incidence now.

Everyone agrees that a campaign against syphilis is a good thing, but certainly such a campaign should be conceived with some regard to scientific and medical knowledge, should not infringe personal liberty unduly, and should be conducted with some measure of economy.

In summary, the results of ten years of openly fighting syphilis, using serologic tests as the leading method of campaigning, are as follows:

1. Public health agencies have received a great deal of publicity.
2. Public health agencies have been greatly expanded.
3. The general public has been informed and grossly misinformed about syphilis.
4. The incidence of syphilis has been decreased by a comparatively small margin.
5. An untold amount of the taxpayers' money has been spent.

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320 Medical-Professional Building.

EXPERIENCES OF A MEDICAL OFFICER IN A JAPANESE PRISON

EMIL P. REED, M. D., F. A. C. S.
DALLAS, TEXAS

To gain a clear understanding of our general condition at the time of imprisonment by the Japanese during the war it is necessary to call attention to the fact that during the campaign on Bataan the American and Filipino forces were early subjected to a limitation of almost 50 per cent normal rations. Later this was again curtailed so that by the time of the surrender troops were getting about a quarter ration. Too, it must be remembered, there were many men engaged in actual combat who were not getting their rations regularly.

During the last month before surrender I was seeing cases of beriberi among the troops of the 26th Cavalry, a Philippine regiment. There were many cases of malaria appearing, perhaps 5 to 8 a day. Early in the campaign quinine became scarce and its use prophylactically was discontinued. Cases of bacillary dysentery were appearing, which was not surprising because of the extreme difficulty in maintaining sanitary conditions.

During the last few days before the actual surrender of Bataan, the Japanese had already started their push and in several places American lines were broken and the units had evaporated. Many of the men who had spent all this time on the front line were seen wandering to the rear. The deplorable emaciated condition of these men is beyond description. It can be seen that we were well along the road to starvation before we became prisoners.

On April 8, 1942, word was received that our forces had surrendered and that the only instructions from the Japanese were to get on the main road and start marching north. Thus was started the March out of Bataan.

The distance covered by our group on this march was about seventy-nine miles, which was covered in five days. During this time I received one mess-kit helping of rice and even this was more than many of the other men and officers received. The last stretch of this march was continuous, starting at 5 o'clock one afternoon and ending at 3 the next afternoon. The lack of food was not felt anywhere near as acutely as the desire for water. At times the thirst was so unbearable that some men were prompted to rash acts. During each twenty-four hour period during this march I would urinate once possibly 2 or 3 ounces of a very dark amber fluid. This was certainly a perfect concentration test.

By the time our destination, Camp O'Donnell, was reached, a more wretched mob of men was never seen. Everyone was sick and emaciated, and men were crawling off to tall grass to die like animals. The water supply here was far from adequate, the living conditions being comparable to those of animals. The death rate from starvation, malaria, and dysentery continued to rise until the Americans were dying at the rate of about 100 a day and the Filipinos at about 250 a day. The latrines were open pits, the Japanese not allowing any change to be made. A tremendous horde of flies was the result.

By this time nutritional edema was appearing in a large number of the men. Aching feet of beriberi was on the increase and almost everyone had dysentery. The small amounts of medicine that had been brought into camp in field medical kits was exhausted very early. It is beyond the imagination of one not present to see the hopeless condition under which we were living. The personnel of the Medical Department were just as sick, weak, and starved as the rest.

During the two months at this camp I was in charge of the so-called out-patient department. It was a most discouraging thing to stand weakly and listen to the complaints of others and then have nothing to give them.

The Japanese were evidently determined to do nothing for their prisoners. Repeated requests for food and medicine went unanswered. On one occasion the Japanese made a formal inspection of the area and were evidently somewhat moved by the large number of cases of dysentery. They ordered us not to allow as many cases of it to occur.

By June, 1942, conditions had become so terrible that the Japanese finally decided to move us to a camp with more facilities for such a large group of men. During the first week in June we were transferred to a camp at Cabanatuan. At this place housing facilities and the water supply were much better.

At this new camp instructions were given to form a definite organization. The camp was divided into three groups of 1,500 to 2,000 men each. There was a headquarters section and a hospital. The camp was organized somewhat along military lines. All business with and regulations from the Japanese were conveyed from their headquarters to ours and then were administered by our organization.

I was placed in charge of the dispensary of group one. There were five other officers serving with me and the medicine we practiced was novel, to say the least. Sick

Read before the Section on Radiology and Physiotherapy, State Medical Association of Texas, Annual Session, Galveston, May 8, 1946.

call would be held each day and an attempt made to do something for the men even if the medicine used was inert. During practically all of 1942 there was no medicine of any kind and much improvisation was resorted to, to have anything to work with. It was the feeling of medical officers that, at least for morale purposes, something should be available for all who came to the dispensary. Charcoal was obtained and mixed with some starch. This mixture was given to the dysentery patients and the men would go away at least with the feeling that something was being done for them. A fairly good number even claimed improvement under such therapy.

It is of interest that charlatanism had to be dealt with even in our prison. One day one of the men came to sick call with the complaint of dysentery and stated that it was much worse after taking some medicine he had bought from another American for $3. He brought the bottle with him and it contained nothing but soapy water.

During all of 1942 and part of 1943 the only reference book the medical officers had was a Merck's *Manual* that one of them had brought into the camp. It was a good thing that that company had put out such a usable and reliable book. It was of much help in dealing with diseases which in many cases were usual in the tropics but with which the American medical officers had not had much experience. On one occasion the Japanese doctor ordered the doctors of our group to write a complete paper on beriberi. Being suspicious of his intentions, one of the medical officers conceived the idea of copying word for word the dissertation on beriberi as given in Merck's *Manual*. This was done and the report submitted to the Japanese doctor. He was very pleased but we never heard any more from it. I wonder to this day if it was sent to Japan and found its way into some Japanese medical journal.

During this particular time the question of surgery often presented a considerable problem. A patient with any surgical condition of emergency proportions which arose at a time that suited the schedule of the Japanese might be placed in a truck and taken into some Japanese hospital and cared for there. One night there was a case of acute appendicitis. The Japanese doctor was informed and was told the patient should be operated on immediately. He consulted his superiors and after some delay he replied that he was so sorry, but the trucks could not go to town that night. He asked that the patient be treated there. We tried to instruct him in the dangers of appendicitis and he was very moved. He wanted to know if there was anything else that could be done. He was told that the only other thing to do was to put ice packs on the patient's abdomen for relief. He said he was sorry but there was no ice but he would try to find some. The patient recovered in spite of the treatment and in two days was back to duty. Three days after the above request the doctor called us to come get the ice to cure the man. We received a 300 pound cake of ice and had ice water the rest of that day, something we had not had for months.

The month of December, 1942, brought a change for the better. At this time the Japanese began to issue a little more food and some medicine, but in particular quinine. They had evidently received an enormous shipment of this drug from the Dutch East Indies and from that time on until our release quinine was the one drug available in sufficient amount. At Christmas that year, the first Red Cross food and medicine was received and the "pick-up" it gave the men was tremendous. More or less everyone began to gain weight, nutritional edema began to subside, beriberi improved, and the morale was much better.

At this time the Japanese began making some effort to issue medicine to the prisoners. In particular a truck load of patent medicines was brought into the camp from an American owned drug store in Manila. All of the garden varieties of nostrums that can be seen in any five and ten cent drug store in the United States and many oriental varieties in addition were represented in this assortment. Thanks to the food and drug laws the contents of most of these drugs were printed on the labels and we were able to utilize most of them in one way or another.

One preparation called "Doctor William's Pink Pills for Pale People" was received in large amounts. It contained small amounts of iron, so that by giving it in heroic doses it was possible to get some iron into patients. Many laughs and a few risque suggestions were produced when carton after carton of "Lydia Pinkham's Compound" were opened. Certainly there were no women in our camp and in fact we had not even seen a woman in months; consequently it was a question as to how to use this compound. The ingredients as stated on the label were of no help. There had been a large amount of codeine powder in the Red Cross medicine, and we decided that Lydia's Compound could be used as a vehicle for codeine in a cough mixture. This made a very passable cough medicine. At about this time there was an epidemic of mastitis among some of the men. This was characterized by a considerable swelling just beneath the nipple. Some of the poor fel-

lows with this mastitis felt that their troubles were caused by our administration of Lydia's Compound to them. Poor Lydia must have turned over in her virginal grave to think of the use her nostrum was being subjected to.

During 1943 practically all of the equipment of one of the large American general hospitals on Bataan was brought by truck to the camp and turned over to us to equip the hospital. That which had been hospital in name only up until then became one in fact. The hospital area was divided so that there were barracks for tuberculosis cases, others for amebic cases, a ward for surgical cases, wards for general cases, and a makeshift operating room.

A very characteristic thing for everyone in camp was to develop what was called "rice belly." This was caused by general malnourishment and the resulting loss of muscle tonus. Many new cases of inguinal hernia were appearing. Some attempts at repair were made but they immediately broke down in most cases, in fact, even in the cleanest and simplest cases. This was positive evidence of the importance of a satisfactory protein balance and the poor healing that will occur in a case of hypoproteinemia. After that surgery was limited to emergency cases and hemorrhoidectomies.

The commonest diseases encountered in our camp were the dysenteries, malaria, and the deficiency diseases. The earliest deficiency diseases encountered were beriberi and nutritional edema. Many persons called the latter wet beriberi, but it was the belief of most of the medical officers with whom I talked that the so-called wet beriberi was in reality hypoproteinemia. Beriberi was rampant. Certainly more than 60 per cent of the 12,000 men in the area were afflicted. Before the first Red Cross food and medicine was received the treatment for this disease was a great problem. Our group tried making yeast by planting brewer's yeast on a rice mash with some sugar added. After this had worked for three or four days and just before it started to turn to vinegar it would be rationed to the beriberi patients at one-third to one-half canteen cup doses. Some of the men felt they received some help from this but it was a discouragingly small amount of good. It is of interest to note that quinine was in small amounts an excellent analgesic for aching feet in these patients.

Another frightening condition that was showing up in a large number of the beriberi cases was nutritional amblyopia. This was characterized by a progressive diminution in vision and in many cases scotomata, and objectively by temporal pallor as seen in the ophthalmoscope. Most of these patients later obtained varying amounts of improvement but some also went on to optic atrophy. During 1942 there were a considerable number of cases of xerophthalmia, characterized by corneal ulcers and later in many cases by scarring. I saw only one case that could be definitely called scurvy. This can be accounted for by the fact that during the greater part of the time small amounts of fruit, especially a small tropical variety of lime, could be obtained.

Pellagra became rampant after about four months of prison life. The medical department had been expecting it. There began to appear many men with itching, burning scrotums and at first it was difficult to explain this condition until the patients began to develop soreness of the tips and sides of the tongue with marked sensitivity to hot foods. The diagnosis was then apparent. Soon most of the men showed varying amounts of pellagra from slight oral signs to the full blown type as described in textbooks. Practically all of the pellagra cleared up or improved with the receipt of the first Red Cross packages.

The dysenteries were, like "poor folks," with us the entire time of our prison life. During the first six months, when so many men were dying, I believe the bacillary type was the causative factor. Constitutional signs and symptoms were marked. Later the amebic type came into its own. All types and grades of severity were encountered and the estimate of the men afflicted ran between 25 and 40 per cent. There were surprisingly few cases of liver abscess. There was nothing to combat this disease until receipt of the second shipment of Red Cross medicine in December, 1943.

During the middle and latter part of 1944 many cases of dengue developed. This was characterized by severe aching and headache that aspirin would not relieve. It was also about this time that the Japanese began to issue a partially decomposed fish that during ordinary times the Filipinos sell for $2 or $3 a ton for fertilizer. We had begged and pleaded for some form of protein and so they let us have this fish. The fish conglomeration smelled as bad as any spoiled fish can smell. By this time our whole life had become wrapped up in food and the quest for food. After some experimenting it was found that the only way this fish could be prepared in anything like a palatable way was to bake it to a crisp dryness and then to grind it into a powder. Sprinkled on rice it had a faintly fish flavor and was salty and thus could be eaten.

Soon a peculiar epidemic appeared which the soldiers called "limber neck." Subjec-

tively there were (1) drooping of the eyelids, (2) weakness of the extensor muscles of the head, allowing the head to nod and often drop forward helplessly on the chest, (3) inability to fix the vision on objects. Less frequently there were (4) drooping of the lower lip, causing drooling, (5) weakness of the muscles of mastication, resulting in inability to eat an entire meal without periodically resting, (6) weakness of the upper extremities, (7) weakness of both the upper and lower extremities, (8) wrist drop, (9) foot drop.

Objectively all patients were found to exhibit the following: (1) lateral nystagmus, (2) contraction of visual fields for color, (3) rapid fatigue of eye and neck muscles. Less frequently found were (4) weakness of the levator palpabrae superioris, usually bilateral, (5) weakness and occasionally paralysis of one or more of the external ocular muscles (extra ocular palsies), (6) weakness of extensor muscles of the neck. A few cases also showed (7) weakness of muscles, especially extensors of the arm and forearm, (8) wrist drop, (9) weakness of arm and leg muscles, occasionally foot drop, (10) weakness of muscles of mastication, (11) weakness of muscles of deglutition, (12) weakness of muscles of facial expressions.

This disease struck both the healthy and sick alike and the state of nutrition had no relation to the number of cases. Exercise brought on the symptoms and rest caused the symptoms to subside or clear up for a period. The usual story given was as follows: "I had been going about my affairs as usual when I noticed a marked difficulty in keeping my eyes open," or "While picking camotes up from the ground, I suddenly found I couldn't raise my head," or "While chopping wood I suddenly felt very weak, my eyelids wouldn't stay up, my head dropped forward on my chest, and I had to be helped in from work because of weakness," or "I can't eat my entire meal without stopping to rest, as I have difficulty in chewing and swallowing." These symptoms often cleared up in a few hours only to return with attempted use of the muscles affected.

Most of the cases developed during November and December, 1944. About 400 of the 511 prisoners in the camp were affected to some degree. Most of the cases were mild, exhibiting perhaps only the ptosis as a subjective symptom. As to the etiology, many possibilities were considered—chemical, bacterial, or virus. At first the possibility of a post-dengue encephalitis was considered. Later it was noted that a large part of a group assigned to work in the mess did not have the affliction. On talking with these men, it was discovered that they did not eat the partially decomposed fish powder which was being issued once each day to the general mess. A group of 50 men who were having symptoms volunteered to cease eating the fish powder entirely as a test. The symptoms in this group completely cleared up in two to seven days. Shortly after this the regular Japanese guard left camp and we started having more or less adequate diet in most essentials, particularly fresh meat, and so the fish powder was no longer served. By the time of our release, twenty-two days later, all cases had cleared up. I believe now this was a form of mild chronic botulism. In treatment, the drugs used experimentally were calcium, ephedrine, adrenalin, strychnine injectible, and oral thiamine. Of these, only strychnine had any apparent effect. An injection made it easier for a man to eat, but its action was very short lived.

The one consistent thing in the diet was rice and most of the time this was not in sufficient amount. The daily average per man in dried polished form was 270 Gm. This gave about 21 Gm. of protein and about 970 calories. Camotes, a tropical variety of sweet potatoes, or cassava were issued at the rate of about 400 Gm. per man. These weights included the pealings. Each man would also get a daily average of about 8 Gm. of cocoanut oil.

For green vegetables camote vines, radish tops, and other tropical plants were issued. These green vegetables were often supplemented with pig weed which grew wild around the camp.

Most of the men maintained small gardens around the living quarters and would occasionally augment the regular meal with okra, eggplant, or squash. Several men built traps to catch dogs and even cats were obtained at times. These were eaten and were even considered to be quite a delicacy. I was fortunate enough to be invited to a dog meal on one occasion and enjoyed it very much.

From the above figures it can be seen that the calories of our diet amounted to about 1,500 or less per day and the protein about 30 Gm. On rare occasions the Japanese would issue a small amount of meat, but the amount would be so small that by the time it reached the mess kit it could not be identified by sight or taste. On most occasions this issue of meat was made up of the head, hoofs, and offal and every bit of it was utilized.

Because of the demands of both the officers and men, the garbage from the kitchens was passed out in turn to each barrack and

the men and officers would pick through it for any peelings that had been cut too thick and for other bits of edible material.

On one occasion dry corn on the cob was issued. The corn was cooked on the cob, then removed for issue. Soon there was quite an epidemic of corn cobs impacted in the rectum. Many of the men picked these cobs out of the sump and ate them. There was a little flavor in them from being cooked with the corn itself and they filled the emptiness. By the time the masticated corn reached the rectum it had not lost its identity and these were unhappy fellows that had to have their rectums emptied manually of corn cobs.

On the night of January 30, 1945, the stillness was suddenly broken by shooting all around the camp. Within a very few minutes a large group of well fed Americans were in our midst and we were herded out of camp while the Rangers and some guerillas gave us flank and rear guard. We traveled across country all night and by the next afternoon were within our lines and under Old Glory for the first time in three years.

The first few meals we had after our liberation were somewhat difficult to take. Some of the men were nauseated and a few vomited. By the time we reached the states, about six weeks after liberation, most of us had regained our old prewar weight. One officer gained more than 70 pounds.

3509 Fairmount, Dallas 4.

PUBLIC HEALTH FELLOWSHIPS

Fellowships in postgraduate public health training for physicians and engineers are being offered by the U. S. Public Health Service for the school year beginning in the fall of 1947. The Health Service will receive applications at any time prior to May 1, 1947, for an academic year's graduate training in an accredited school of public health or an acceptable school of sanitary engineering, followed by three months of field training. The fellowships are made possible by a grant from the National Foundation for Infantile Paralysis through funds contributed to the March of Dimes.

Physician applicants must have completed at least a year's internship and must be citizens of the United States under 45 years of age. Employees of state and local health departments are not eligible. Further details are available from the Surgeon General, U. S. Public Health Service, 19th and Constitution Avenue, N. W., Washington 25, D. C., Attention Public Health Training.

A fact which is not in dispute is that people intimately exposed to tuberculosis infection develop lung tuberculosis more frequently than those who are not so exposed. There is in this fact strong presumptive evidence for the belief that it is fresh infection from without which in many people is responsible for the final lung disease . . . the sputum positive person is a danger to all ages and . . . no immunity in young people will stand repeated reinfections.—Charles Cameron, M. D., NAPT Bull., Feb. 1946.

THE PURPOSE AND VALUE OF THE STANDARD HEALTH UNIT

GEORGE A. GRAY, M. D., F. A. C. P.
SAN ANGELO, TEXAS

The subject of health units and the advantages of them to the medical profession has been presented previously to this section on several occasions. All that has been said in this regard is still true and needs to be emphasized from year to year. It is believed that when all of the practicing physicians of Texas understand the purpose and operation of health units as they are now being established and operated there will not only not be any objection to them but there will be a great demand for them.

Times have changed since the turn of the present century. Medical science has made great strides, and the individual doctor in practice has had to improve his methods and revise his daily schedule and routines to meet the ever increasing demands of an exacting public. Whereas the doctor of fifty years ago travelled in a buggy, had very little overhead office expense, if any, charged small fees, and was regarded almost as a martyr to the cause of suffering humanity by his fellow townsmen, the doctor of today travels in an automobile or an airplane, has a tremendous office expense for the amount of his income, must necessarily charge higher fees, and is regarded by his fellow townsmen as being rich, or in the process of becoming rich, and as being in no need whatever of sympathetic consideration. When such a doctor takes no interest in community affairs, or even opposes projects commonly regarded as being progressive ones, he loses heavily in community respect.

This reasoning and several years observation of my colleagues have caused me to feel that our doctor-public relationship can stand considerable improvement. Consideration should be given to any legitimate means by which physicians can demonstrate to the man-on-the-street that their professional aim is not solely financial gain but that they share with all other progressive citizens a sincere desire to improve the general welfare of the people. I know of no better means by which this end can be accomplished than by supporting, or even promoting, public health in the various communities. Laymen have great respect for preventive measures. They also have a high regard for civic-minded physicians who demonstrate their interest in the community by helping to improve health conditions.

Chairman's Address before the Section on Public Health, State Medical Association of Texas, Annual Session, Galveston, May 7, 1946.

After many years of experience, the State Health Officer and his associates still feel that the standard health unit, made up of doctors, nurses, sanitarians, and the necessary clerical help, offers the most practical and the most economical means of providing preventive medical service for the average American community. Laymen look to their doctors to lead the way in medical matters, and rightly so. Therefore, it is believed that physicians who fail to urge the establishment of a health unit in their county, or group of counties, are missing one of the best opportunities to gain increased respect and prestige in their respective communities.

After a unit is established, it must have the continued support of the local profession if it is to justify the expenditure of money which it costs. One of the surest ways of making a unit unpopular, and even of destroying it, is for the practicing physicians to deny personnel of a unit the privilege of carrying out all legitimate public health, or preventive medicine, practices. While the unit suffers in such cases, understanding laymen discredit also the local profession.

I know of no instance in which the practice of any physician has suffered because of public health activities carried on by health units. On the other hand, I do know of physicians whose practices have been enhanced as a result of public health work. Preventive measures such as immunization and prenatal care are popularized by the publicity which health units can ethically foster through the press, radio, and the use of posters. This results in a larger number of persons who are able to pay going to their physicians for such service. The same is true in case-finding activities carried on in health department tuberculosis clinics. No one ever heard of an insurance man complaining about National Service Life Insurance, of which the government sold billions of dollars worth to service men during World Wars I and II. Through newspaper advertisements and orally insurance men urge veterans to hold their government insurance, and to add to it. They say such activity on the part of the government popularizes life insurance and makes more business for them.

Personnel of health units, especially the nurses, are the most competent people I know to interpret to laymen the problems of the medical profession. The public has confidence in nurses. No doubt many of you have observed, as I have, that newspapers give as much weight to the statement of a nurse as to that of a physician. For this reason, I assert that public health nurses are better qualified and are in a more strategic position to combat charlatanism effectively than any other person in the community. Next to the family physician, the public health nurse comes into more intimate contact with people than does any one else. She is the profession's best sales agent of ethical medical service.

The health unit renders services in the community which the busy practitioner does not have time to render. I refer to epidemiological work in particular, ferreting out contacts of venereal disease, tuberculosis, and even of the exanthemata. Explanation of isolation techniques requires much time and is well done by the public health nurse. In fact, it is usually done much better by a nurse than by a doctor. People like this service and are always grateful to the attending physician for making the nurse's service available to them.

The last justification of health units which I shall mention is the most important one. It is my sincere belief that the surest way to prevent the socialization of medical practice is for the profession to promote the establishment and proper operation of health units in all counties of 20,000 or more population, and to make health service available by districts to the more sparsely settled areas. Rather than being an entering wedge for socialized medicine, the properly operated health unit will remove the causes which, if not removed, may bring about socialized medicine in the not distant future. The continuous educational campaign which local health units carry on is an effective and ethical means of keeping the public properly informed on medical matters, and of combatting false publicity which appears in the press and on the radio daily.

Health units are completely under the control of the local medical profession. The State Health Department will not establish a unit without the endorsement of the medical society in whose territory the unit is to operate; the Department will not permit a unit to remain after the local profession votes to discontinue it. On the other hand, socialized medicine would be controlled by lay politicians, and a free medical profession, as we know it today, would no longer exist.

City Hall.

ABSTRACT OF DISCUSSION

Dr. Victor E. Schulze, San Angelo: The public health endeavor of the State Health Department under the direction of Dr. George W. Cox and through the forty-eight affiliated health units in the state is making a distinct contribution to the preservation of the American system of private medical practice. Prudent leaders in the medical profession recognize in this effort a practical, expedient means of correcting for the most part those unfavorable conditions which lend force to the argument of would-be reformers, and for the existence

of which the present system of practice is falsely, but perhaps not unwittingly, blamed. Physicians individually, and not their method, are at fault in so far as they have tolerated the existence of these unfavorable conditions. It behooves physicians, each in his respective community, to use his best influence on the local governing bodies to correct these conditions through establishment and maintenance of standard health units. "Expansion of public health activity," to quote from an editorial of *The Journal of the American Medical Association* of September 29, 1945, "is a more sound and logical step toward improving the nation's health than many grandiose plans for medical care." It is my conviction that sponsorship of and coöperation with such activity will prove salubrious likewise to the vocation of private physicians.

MISCELLANEOUS

COMING MEETINGS AND CLINICS

State Medical Association of Texas, Dallas, May 5-8, 1947. Dr. C. C. Cody, Jr., Houston, President; Dr. Holman Taylor, 1404 W. El Paso St., Fort Worth 3, Secretary.

American Medical Association, Atlantic City, N. J., June 9-13, 1947. Dr. Harrison H. Shoulders, Nashville, Tenn., President; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secretary.

Southern Medical Association, November, 1947. Dr. E. L. Henderson, Louisville, Ky., President; C. P. Loranz, Empire Building, Birmingham, Ala., Secretary-Manager.

Southwest Allergy Forum, Shreveport, La., March 31-April 1, 1947. Dr. W. H. Browning, Shreveport, La., President; Dr. Sim Hulsey, Medical Arts Bldg., Fort Worth, Secretary.

Texas Association of Medical Anesthetists, Dallas, May 5, 1947. Dr. Claudia Potter, Temple, President; Dr. Russell Bonham, Box 6237, Houston, Secretary.

Texas Association of Obstetricians and Gynecologists, Fort Worth, November, 1947. Dr. J. E. Kanatser, Wichita Falls, President; Dr. Julius McIver, 714 Medical Arts Building, Dallas, Secretary.

Texas Chapter, American College of Chest Physicians, May 5, 1947. Dr. R. G. McCorkle, San Antonio, President; Dr. Elliott Mendenhall, 1217 Medical Arts Bldg., Dallas, Secretary.

Texas Club of Internists. Dr. Alvis E. Greer, Houston, President; Dr. Julian C. Barton, 414 Navarro St., San Antonio, Secretary.

Texas Hospital Association, Houston, March 27-29, 1947. Tol Terrell, Harris Memorial Methodist Hospital, Fort Worth, President; Mrs. Ruth Barnhart, 2210 Main St., Dallas, Secretary.

Texas Neuropsychiatric Association, Dallas, May 5, 1947. Dr. Fred T. Rogers, Dallas, President; Dr. David Wade, 604 Capital National Bank Bldg., Austin, Secretary.

Texas Orthopedic Society. Dr. E. A. Cayo, San Antonio, President; Dr. Edward Smith, 1215 Walker Ave., Houston, Secretary.

Texas Pediatric Society, Houston, October, 1947. Dr. J. R. Lemmon, Amarillo, President; Dr. John E. Ashby, 3610 Fairmount, Dallas, Secretary.

Texas Public Health Association, Dallas. Dr. L. P. Walter, Austin, President; Mr. Earle W. Sudderth, Dallas County Health Department, Court House, Dallas, Secretary.

Texas Radiological Society, Houston, January 25, 1947. Dr. Herman Klapproth, Sherman, President; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secretary.

Texas Railway and Traumatic Surgical Association, May 5, 1947, Dr. F. L. Snyder, Fort Worth, President; Dr. Ross Trigg, First National Bank Bldg., Fort Worth, Secretary.

Texas Society for Mental Hygiene, San Antonio, April 10-12, 1947. Dr. Jack R. Ewalt, University of Texas Medical Branch, Galveston, President; Mrs. Elizabeth F. Gardner, 1617 Watchhill Road, Austin 21, Executive Secretary.

Texas Society of Gastro-Enterologists and Proctologists, Dallas, May 5, 1947. Dr. Tom E. Smith, Dallas, President; Dr. D. L. Curb, 704 Dallas Ave., Houston, Secretary.

Texas Society of Ophthalmology and Otolaryngology, Houston, December, 1947. Dr. W. E. Vandevere, El Paso, President; Dr. E. D. Dumas, 425 Medical Arts Bldg., San Antonio, Secretary.

Texas Society of Pathologists, Houston, January 26, 1947. Dr. May Owen, Fort Worth, President; Dr. C. T. Ashworth, Southwestern Medical College, Dallas, Secretary.

Texas State Heart Association, Dallas, May 5, 1947. Dr. Robert M. Barton, Dallas, President; Dr. M. B. Whitten, Medical Arts Bldg., Dallas, Secretary.

Texas State Urological Society, Dallas, November or December, 1947. Dr. Jo C. Alexander, Dallas, President; Dr. Hub Isaacks, Medical Arts Bldg., Fort Worth, Secretary.

Texas Surgical Society, Dallas, April, 1947. Dr. Walter Stuck, San Antonio, President; Dr. Truman G. Blocker, University of Texas Medical Branch, Galveston, Secretary.

Texas Tuberculosis Association. F. K. Dougharty, Liberty, President; Miss Pansy Nichols, 700 Brazos, Austin, Executive Secretary.

Third, Panhandle, District Medical Society, Amarillo, April 8-9, 1947. Dr. W. A. Carroll, Claude, President; Dr. George Powers, Fisk Bldg., Amarillo, Secretary.

Fourth District Medical Society, Coleman, 1947. Dr. Glenn H. Ricks, Brady, President; Dr. J. C. Young, Coleman, Secretary.

Seventh, Austin, District Society. Dr. Robert B. Morrison, Austin, President; Dr. M. I. Brown, Capital National Bank Bldg., Austin, Secretary.

Eighth, Ninth and Tenth Districts Medical Society, Orange, April, 1947. Dr. Walter F. Hasskarl, Brenham, President; Dr. George W. Waldron, Medical Arts Bldg., Houston, Secretary.

Eleventh District Society. Dr. L. L. Travis, Jacksonville, President; Dr. C. B. Young, 929 S. Confederate, Tyler, Secretary.

Twelfth, Central Texas, District Society, Temple, January 14, 1947. Dr. Thomas G. Glass, Marlin, President; Dr. H. F. Connally, Jr., Amicable Bldg., Waco, Secretary.

Thirteenth, Northwest District Society, Abilene, Spring, 1947. Dr. Frank Hodges, Abilene, President; Dr. Robert C. Stokes, 501 First National Bank Bldg., Fort Worth, Secretary.

Fourteenth District Society. Dr. C. B. Thayer, Gainesville, President; Dr. V. L. Tuck, Sherman, Secretary.

Fifteenth, Northeast Texas, District Society. Dr. Joe Roberts, Longview, President; Dr. S. W. Tenney, Marshall, Secretary.

CLINICS

Dallas Southern Clinical Conference, Dallas, March 17-20, 1947. Miss Thelma J. Webb, 1133 Medical Arts Bldg., Dallas 1, Executive Secretary

International Postgraduate Medical Assembly of Southwest Texas, San Antonio, January 28-30, 1947. Dr. A. Fletcher Clark, 827 Medical Arts Building, San Antonio, President.

New Orleans Graduate Medical Assembly, New Orleans, February 24-27, 1947. Dr. Max M. Green, Room 105, 1430 Tulane Ave., New Orleans 13, Secretary.

HOSPITALS NEEDING INTERNS AND RESIDENTS

Methodist Hospital, Dallas. Capacity 206 beds. C. B. Fielder, Superintendent (interns desired, July, 1947).

El Paso City County Hospital, El Paso. Capacity 192 beds. George W. Cook, Col., U. S. A., Ret., Superintendent (3 interns for one year term, graduates of class A medical school only).

SCIENTIFIC AND MOTION PICTURE EXHIBITS NEEDED

Scientific exhibits and motion pictures for display at the annual session of the State Medical Association in Dallas, May 5-8, are being solicited by Dr. X. R. Hyde, Fort Worth, chairman of the Committee on Scientific Exhibits.

Any member of the Association who can supply an interesting display for the scientific exhibit is urged to write Dr. Hyde at the Medical Arts Building, Fort Worth, for an application blank on which the requirements of each exhibit will be made clear. Completed blanks must be returned to Dr. Hyde by April 1.

Physicians with motion pictures they would like to exhibit should also write Dr. Hyde for application blanks. Films to be shown at the annual session are subject to review by committees appointed by the Board of Trustees, and no film may be shown which has not been approved by the appropriate committee. To allow time for such review, films must be sent by March 1 to the Motion Picture Film Library, State Medical Association, 1404 West El Paso Street, Fort Worth 3.

The practicing physician is an extremely valuable tuberculosis case-finding agent, since he is in a position to discover a vast number of persons with tuberculosis. Indeed, a large portion of patients see him before anyone else. These opportunities for diagnosis are particularly significant at this time, since war, as always, has increased the incidence of tuberculosis.—I. D. Bobrowitz, M. D. and Ralph E. Dwork, M. D., New England J. Med., Jan. 11, 1946.

LIBRARY OF THE
COLLEGE OF PHYSICIANS

MEDICAL OFFICERS RETURNING TO TEXAS*

(Correction: F. C. Harmon, previously listed in both Paducah and Floydada, should be listed only in Paducah.)

NAME	Serv.†	Location	Release Date
Bell County			
20. Brindley, Clyde O.	A	Temple	
Bexar County			
163. Davis, Herman L.	A	San Antonio	
164. Davis, Roy N.	A	San Antonio[1]	
165. Franken, Robert	A	San Antonio	Sept., 1946
166. Mathis, Robert L.	N	San Antonio	
167. Pawelek, Vincent S.	A	San Antonio	
168. Smith, John M., Jr.	A	San Antonio	
169. Wilson, Harry G.	A	San Antonio	
Cameron-Willacy Counties			
25. Williams, Frank C., Jr.	N	Los Fresnos	
Cass-Marion Counties			
5. DeWare, Jesse M.	A	Jefferson[2]	Dec., 1945
Colorado County			
6. Youens, Willis G., Jr.	A	Columbus	
Dallas County			
237. Atkinson, George N.	N	Dallas	
238. Bassett, Wallace H.	A	Dallas	
239. Denson, Judson S.	A	Dallas	
240. Kantor, Herman I.	A	Dallas	July, 1946
241. Lipschultz, Bernard M.	A	Dallas	June, 1946
242. Lipscomb, Cuvier P.	A	Dallas[3]	
243. Miller, F. Fox	A	Dallas	
244. Millwee, Robert H.	A	Dallas	June, 1946
245. Richman, Irving M.	A	Dallas	
246. Schuessler, Willard W.	A	Dallas	
247. Shelton, James L.	A	Dallas	
248. Vassallo, Alfred L.	A	Dallas	
249. Watkins, Dale	A	Dallas	June, 1946
El Paso County			
71. Cameron, Bruce M.	N	El Paso	
72. Lee, Henry M.	A	El Paso	

[1]Formerly of Houston.
[2]Formerly of Gladewater.
[3]Formerly of Denison.

*EDITOR'S NOTE: This list is the fifteenth of a series in which it is hoped to name all those physicians who have been in the Armed Forces during the war recently passed and have now returned to Texas to resume civilian practice. The information in this list has been assembled from a variety of sources. While an attempt has been made to secure as complete and as accurate data as possible, we are aware that omissions and errors have been made. Not only for publication in the JOURNAL but also for the permanent records in the central office of the State Medical Association, we invite and urge correction of and addition to the material here submitted. Note that physicians from each county area are numbered consecutively following those listed in the December JOURNAL; the last number in each section therefore indicates the total physicians returned to that county area. The complete total for Texas named to date (December 26), including the accompanying list, is 2,010.

†A=Army; N=Navy; U=U. S. Public Health Service.

NAME	Serv.†	Location	Release Date
Erath-Hood-Somervell Counties			
7. Johnson, W. J.	A	Stephenville	
Falls County			
10. Buie, Neil D., Jr.	N	Marlin	
Fannin County			
9. Roach, Paul A.	N	Ladonia	
Freestone County			
1. Smith, Lex B.	N	Teague	
Galveston County			
65. Spencer, James R., Jr.	N	Galveston	
Hardin-Tyler Counties			
5. Pope, James W.	A	Doucette	
Harris County			
290. Daily, Louis, Jr.	N	Houston	
291. Shirley, Carl W.	N	Houston	
Hidalgo-Starr Counties			
14. Whittenburg, Ross E.	A	McAllen	
Jefferson County			
59. Keith, Frank	N	Port Arthur	
60. Payne, Beverly C., Jr.	N	Beaumont	
Lampasas-Burnett-Llano Counties			
5. Gaddy, Howell R., Jr.	N	Lampasas	
Liberty-Chambers Counties			
7. Schulz, Don P.	A	Hull	Oct., 1946
Lubbock-Crosby Counties			
30. Gordon, William H., Jr.	N	Lubbock	
31. Ward, James F.	N	Lubbock	
McLennan County			
54. Hardgrove, Thomas J.	A	Waco	
Nolan-Fisher-Mitchell Counties			
11. Woodward, Joe W.	N	Sweetwater	
Tarrant County			
90. Badt, Morris B.	A	Fort Worth	
91. Petta, George H.	A	Fort Worth	
92. Walker, James N.	A	Fort Worth[1]	Jan., 1947
Taylor-Jones Counties			
22. Burns, Coleman C.	A	Abilene[2]	May, 1945
23. Stanford, Henry	A	Abilene[3]	
Travis County			
67. Bailey, Joe W.	N	Austin	
68. Gatoura, George J.	A	Austin	
69. Rainer, James W.	N	Austin	
70. Swearingen, Revace O.	A	Austin	
71. Whitten, John W.	A	Austin	
72. Worley, Gordon, Jr.	N	Austin	
Walker-Madison-Trinity Counties			
11. Leifeste, Homer F.	N	Madisonville	

[1]Formerly of Dallas.
[2]Formerly of Henderson.
[3]Formerly of Temple.

TEXAS STATE UROLOGICAL SOCIETY

More than one hundred urologists attended a meeting of the Texas State Urological Society on December 2 at Jefferson Davis Hospital, Houston. Organized last May, the society made an effort in its recent meeting to develop an informal program in which problems of mutual interest could be discussed and opportunity given for urologists of the state to become better acquainted. Dr. Laurin McCrea, Philadelphia, was a special guest.

The following program was presented:

Operative Clinic.
- Plastic Operation on the Male Perineum—Dr. B. Weems Turner, Houston.
- Transurethral Prostatic Resection—Dr. Ross Margraves, Houston.
- Perineal Prostatectomy—Dr. Michael K. O'Heeron, Houston.

Ward Rounds over Urology Service of Jefferson Davis Hospital—Dr. Cecil M. Crigler, Urologist on Service.

Current Medical Problems in Urology—Drs. M. G. Rape and Joe Roberts, Resident Urologists, Jefferson Davis Hospital, and All Urologists Present.

"Free for All": General Discussion of Difficult and Interesting Cases—Dr. B. Weems Turner, Houston, presiding.

During a business meeting at the conclusion of luncheon at the Warwick Hotel, Dr. Jo C. Alexander, Dallas, was reelected president and Dr. Hub Isaacks, Fort Worth, was elected secretary. It was decided to hold the next meeting in Dallas in either November or December, 1947.

Dr. B. Weems Turner was host in the afternoon for a cocktail party at his home, after which the group had dinner at the College Inn.

INTERNATIONAL MEDICAL CONGRESS

The second International Medical Congress will be held at the Ancira Hotel, Monterrey, Mexico, on February 7 and 8, with scientific papers by physicians from the United States and Mexico. In February, 1944, the first congress was held in Laredo with the Texas Tuberculosis Association and Southwest Texas District Medical Society as sponsors. The following May the State Medical Association of Texas in its annual session voted to join in sponsoring future meetings of the congress. Rulings from the Office of Defense Transportation forced cancellation of a meeting in 1945 and no attempt was made to hold a meeting in 1946, so that the meeting in February, 1947, will be the first congress with the State Medical Association as a sponsoring organization. Other sponsors include the National Tuberculosis Association, U. S. Public Health Service, and

Pan American Sanitary Bureau. No registration fee will be charged.

Monterrey hotels have set aside rooms to accommodate visiting physicians, but reservations should be made in advance. Reservations for Texas physicians are being handled by Miss Pansy Nichols, Executive Secretary of the Congress, 700 Brazos Street, Austin. Miss Nichols states that requests for reservations should include the names of persons in the party, the number and type of rooms desired, and the date of arrival. An advance deposit of $6 per person, which will be deductible from the total hotel bill, is required by the hotels and should be sent with the request for reservation to Miss Nichols.

The tentative program for the International Medical Congress, which opens at 9:30 a. m., February 7, follows:

FEBRUARY 7

Address of Welcome—Dr. Dante Decanini, Monterrey.
Response—Dr. McIver Furman, Corpus Christi.
Evaluation of the Methods and Treatment of Tuberculosis and Pathological Standards—Dr. Julius Lane Wilson, New Orleans.
Recent Advances in Pediatrics—Dr. Amos Christie, Professor of Pediatrics, Vanderbilt University School of Medicine, Nashville, Tenn.
Tuberculosis Infantil en Mexico—Dr. Luis Berlanga Berumen, Mexico.
Luncheon.
Extra Pleural Pneumothorax (motion picture)—Dr. Carlos Noble, Mexico.
Modern Methods in the Treatment of Syphilis with Discussion of Some of the Complications which Occur During Treatment—Dr. John Mahoney, U. S. Public Health Service, Washington, D. C.
Infant Feeding—Dr. Amos Christie, Nashville, Tenn.
Angioneumografia—Dr. Alejandro Celis, Mexico City.
Nominations for Officers for 1947.
Dinner—Dr. Carlos Medina C., Monterrey, Toastmaster.
Introduction of Guests.
Address of the President—Dr. Ismael Cosio Villegas, Mexico City.

FEBRUARY 8

Principles Underlying the Management of Tuberculosis in Pregnancy—Dr. Julius Lane Wilson, New Orleans.
False Positive Reaction in the Serology of Syphilis—Dr. John Mahoney, Washington, D. C.
El Dispensario Anti-Venereo—Dr. E. Ramirez, Mexico.
Luncheon.
Program for the Control of Tuberculosis.
The Role of the Official Health Agency—Dr. Robert J. Anderson, U. S. Public Health Service, Washington, D. C.
The Role of the Voluntary Health Agency—Dr. E. G. Faber, President, Texas Trudeau Society, Tyler.
The Program in Mexico (motion picture)—Dr. Cosio Villegas, Mexico City.

DALLAS SOUTHERN CLINICAL CONFERENCE

The sixteenth annual spring conference of the Dallas Southern Clinical Society has been arranged for March 17-20 in Dallas with fifteen outstanding physicians as guest speakers. General assemblies, postgraduate lectures, clinics, round-table discussions, motion pictures, and technical exhibits have been planned to give both the general practitioner and the specialist practical teaching.

Guest speakers include:

Dr. Elmer Belt, Los Angeles (urology).
Dr. William Boyd, Toronto, Canada (pathology).
Dr. Frank D. Dickson, Kansas City (orthopedic surgery).
Dr. F. Bruce Fralick, Ann Arbor, Mich. (ophthalmology).
Dr. L. H. Garland, San Francisco (radiology).
Dr. George H. Humphreys, New York (surgery).
Dr. J. R. Lindsay, Chicago (otolaryngology).
Dr. Perrin H. Long, Baltimore (preventive medicine).
Dr. H. G. Poncher, Chicago (pediatrics).
Dr. I. S. Ravdin, Philadelphia (surgery).
Dr. Ralph A. Reis, Chicago (obstetrics and gynecology).
Dr. Newton D. Smith, Rochester, Minn. (proctology).
Dr. Williard Owen Thompson, Chicago (medicine).
Dr. John C. Whitehorn, Baltimore (neuropsychiatry).
Dr. Julius L. Wilson, New Orleans (medicine).

All features of the conference, including luncheons and the annual clinic dinner, are included in the registration fee of $15. Any member of a county medical society is invited to participate. Sessions will be held at both the Adolphus Hotel, which is conference headquarters, and the Baker Hotel, and physicians planning to attend are requested to make reservations directly with the hotel of their choice as promptly as possible. Additional information may be secured from the society at 433 Medical Arts Building, Dallas 1.

SECRETARY-EDITOR CONFERENCE

The annual Conference of State Medical Association Secretaries and Editors was held at American Medical Association headquarters in Chicago on December 7 and 8, immediately preceding the supplemental session of the House of Delegates. An unusually large attendance was recorded for the conference, at which the State Medical Association of Texas was officially represented by Dr. Holman Taylor, Secretary-Editor, and Dr. R. B. Anderson, Assistant Secretary-Editor, both of Fort Worth. Also attending the conference was Harriet Cunningham, Fort Worth, assistant to the editor.

Following opening remarks by Dr. R. L. Sensenich, South Bend, Ind., chairman of the Board of Trustees of the American Medical Association, Dr. Julian P. Price, secretary-editor of the South Carolina Medical Association, Florence, was elected chairman of the conference and presided over the following program:

DECEMBER 7

The American Medical Association—Dr. George F. Lull, Secretary and General Manager, American Medical Association, Chicago.
State Medical Society Participation in Network Broadcasting—Dr. W. W. Bauer, Director, Bureau of Health Education, American Medical Association, Chicago.
The State Medical Society and the State Government—Dr. Creighton Barker, Secretary, Connecticut State Medical Society, New Haven.
The Responsibility of the Individual Physician—Dr. James C. Sargent, Milwaukee, Wis.
Luncheon.
State Medical Association and Social Security and Federal Income Taxes—Thomas V. McDavitt, American Medical Association, Chicago.
The County Medical Society—M. L. Meadors, Director of Public Relations, South Carolina Medical Association, Florence, S. C.
The Cooperative Medical Advertising Bureau—Dr. Stanley B. Weld, Editor in Chief, Connecticut State Medical Journal, Hartford.
The Medical Profession and Public Relations—Charles Swart, Executive Assistant, American Medical Association, Chicago.
Dinner.
Address—Hon. A. L. Miller, M. C., Fourth District, Nebraska.
Session for Secretaries—Dr. Douglas L. Cannon, Secretary, Medical Association of the State of Alabama, Montgomery, presiding.
Commercial Exhibits—Dr. L. Fernald Foster, Secretary, Michigan State Medical Society, Lansing.
The Home Office of a State Medical Association—R. H. Graham, Executive Secretary, Oklahoma State Medical Association, Oklahoma City.
Session for Editors—Dr. Robert N. Nye, Managing Editor, New England Journal of Medicine, Boston, presiding.
The Medical Editor Consults His Readers—Theodore Wiprud, Managing Editor, Medical Annals of the District of Columbia, Washington.
Our Concept of the Function of a State Medical Journal—Dr. Jonathan Forman, Editor, Ohio State Medical Journal, Columbus.

DECEMBER 8

Introduction of Governor Green—Dr. Robert S. Berghoff, President, Illinois State Medical Society, Chicago.
Address—Hon. Dwight H. Green, Governor of Illinois, Springfield.
Reports from Sessions for Secretaries and Editors—Drs. Cannon and Nye.
Open Forum—Dr. Julian P. Price, presiding.

The conference also heard Rear Admiral Joel T. Boone, M. C., U. S. N., who has been directing an investigation of health conditions among coal miners at the request of Secretary of the Interior Krug.

UNIVERSITY OF TEXAS OFFERS PHYSICAL MEDICINE COURSE

A postgraduate course in physical medicine will be held at the University of Texas Medical Branch, Galveston, March 3-7, for physicians and qualified physiotherapy technicians. Dr. W. A. Selle, professor of physiology and chairman of the course, offers to supply additional information about the course, which is designed for physicians interested in the use of physical medicine in general practice as well as in the medical specialties. Instruction in the theory and technique of application of various physical agents, demonstrations, and motion pictures will be used to emphasize the practical, clinical aspects of physical medicine.

Visiting participants in the physical medicine course will be the following:

Dr. Robert L. Bennett, Professor of Physical Medicine, Emory University Medical School, Emory University, Ga.

Dr. Ben L. Boynton, Director of Physical Medicine, Shannon West Texas Memorial Hospital, San Angelo.

Dr. Donald A. Covalt, Assistant Medical Director, Medical Rehabilitation and Physical Medicine, Veterans Administration, Washington, D. C.

Dr. Victor P. Diederich, Hot Springs, Ark.

Dr. Earl C. Elkins, Consultant on Physical Medicine, Mayo Clinic, Rochester, Minn.

Dr. Richard Kovacs, Professor of Physical Medicine, New York Polyclinic Medical School and Hospital, New York.

Dr. Gordon M. Martin, Director of Physical Medicine, Assistant Professor of Medicine, University of Kansas Medical School, Kansas City, Kan.

Dr. Frank R. Ober, John B. and Buckminster Brown Clinical Professor of Orthopedic Surgery, Harvard University Medical School, Boston.

Dr. George Morris Piersol, Professor of Medicine, Graduate School of Medicine, and Professor of Clinical Medicine, School of Medicine, University of Pennsylvania, Philadelphia.

Dr. Oscar O. Selke, Director of Physical Medicine, Hermann Hospital, Houston.

Dr. Hart E. Van Riper, Medical Director, National Foundation for Infantile Paralysis, New York

Dr. Arthur L. Watkins, Associate in Medicine, Harvard Medical School, and Chief of Physical Medicine, Massachusetts General Hospital, Boston.

Members of the University of Texas staff will also assist.

A general fee of $25 will be charged to cover instruction in the physical medicine course. Those who desire certification of attendance will be required to pay an additional $2 fee.

MEDICAL RECORD LIBRARIANS INSTITUTE

Standard nomenclature in medical records was the theme of an institute for medical record librarians held under the sponsorship of the American Hospital Association and the American Association of Medical Record Librarians in Dallas, December 2-6. More than one hundred medical record librarians and hospital administrators attended the institute, the fourth conducted jointly by the two associations to present a basic and elementary course in medical record methods to combat the shortage of trained medical record librarians.

CONFERENCE ON MEDICAL SERVICE

The twentieth annual meeting of the National Conference on Medical Service will be held at the Palmer House, Chicago, on February 9, Dr. Creighton Barker, New Haven, Conn., secretary of the conference announces. The program will include discussions in the fields of national affairs, economics, and medical education. There is no registration fee and all physicians are invited to attend.

BILL TO ESTABLISH TUBERCULOSIS SANATORIUMS*

Section 1. There is hereby created and established and there shall be maintained by the State of Texas two tuberculosis sanatoriums, in addition to those already established, for the examination, isolation and medical and surgical care, treatment and support of those suffering from tuberculosis. They shall be known as State Tuberculosis Sanatoriums. After the said sanatoriums have been located then the name of the town near which they are located shall be added to the name so as to thereafter read ——————————State Sanatorium. One Sanatorium shall be located at some point and in some county which is located within the First, Third or Seventh Congressional District, as those districts are now defined by law. One sanatorium shall be located at some point and in some county which is situated within the Fourteenth or Fifteenth Congressional District as is now defined by law.

Section 2. The Board of Control of the State of Texas shall select the site for each sanatorium provided for in this Act and the Board, in selecting such site, shall make such selection with a view to its accessibility and convenience, the supply of water, building material, fuel, fertility of soil and healthfulness, and the same shall contain not less than three hundred (300) acres of land. Said Board shall take title to the land so selected by them in the name of the State of Texas for the use and benefit of said sanatoriums; provided, however, that the Attorney General's Department shall first approve the title to said land so selected by the said Board.

Section 3. At the completion of the buildings and when the said sanatoriums are ready to open, the Board of Control shall appoint a Superintendent and other employees to superintend and carry on the work of such sanatoriums as is now provided by the General Laws of the State of Texas governing like State institutions. The support and general maintenance and regulation of said sanatoriums shall be the same in every respect as is provided for other State Tuberculosis Sanatoriums as now provided by law.

Section 4. There shall be constructed upon said grounds so selected permanent, suitable, substantial, and fireproof buildings at each such sanatorium provided for herein to accommodate at least two hundred (200) patients; said buildings to be provided with modern improvements for furnishing water, heating, ventilation and sewerage; and the Board of Control immediately after this Act goes into effect and after the selection of the sites for the said sanatoriums, and after the title of said land shall have been approved by the Attorney General, shall advertise for plans and specifications for said buildings at each location and shall contract for the erection of same; and shall have the power and authority to do and perform all things necessary for carrying out the purpose of this Act. Provided that all buildings authorized by this Act, and for which an appropriation is hereby made, shall be of fireproof construction, and that the part of all plans and specifications for the erection of said buildings relating to fire protection shall be subject to the approval of the State Fire Insurance Commission.

Section 5. There shall be and there is hereby appropriated out of the General Revenues of this State not otherwise appropriated the sum of One Million, Six Hundred Thousand Dollars ($1,600,000) which shall be distributed equally between the two sana-

*A bill to be introduced in the Fiftieth Legislature to establish two tuberculosis sanatoriums in Texas. The bill has been approved by the Texas Tuberculosis Association and the Executive Council of the State Medical Association of Texas. Editorial discussion of the bill may be found on page 518 of this JOURNAL.

toriums provided for in this Act for the buildings and improvements and in securing the lands for the site and the expenses incurred in connection therewith. In the expenditure of the above amounts, the Board of Control shall have the authority to make proper adjustments in regard thereto. Provided further, that in case suitable sites are donated or can be acquired from the Federal Government or any of its agencies, no lands shall be purchased. Provided, also, that the Board of Control shall also be authorized to accept, in behalf of the State, for said purposes, suitable tracts of land donated or given to the State as sites for said sanatoriums. Or may acquire long term leases from the Federal Government, or any of its agencies, of suitable tracts of land within the Congressional Districts as set forth under this Act.

Section 6. The fact that tuberculosis is a communicable and infectious disease and is prevalent in the sections of the State set forth under this Act, constituting a menace to the general health and welfare of all of the people of the State, creates an emergency and an imperative public necessity that the Constitutional Rule requiring bills to be read on three several days in each House be suspended, and that said Rule is hereby suspended, and this Act shall take effect and be in force from and after its passage, and it is so enacted.

LIBRARY NOTES

PACKAGE SERVICE

The package library consists of collections of reprints and other periodical material on various subjects, prepared for lending to members of the Association. Requests for packages should be addressed "Library, State Medical Association of Texas, 1404 W. El Paso Street, Fort Worth 3, Texas." Twenty-five cents in stamps should be enclosed with the request to cover postage and part of the expense of collecting the material. Only one package may be borrowed at a time, and packages are allowed to remain in the hands of the borrower for 14 days.

Packages were mailed from the Library of the State Medical Association to the following during December:

Mrs. Ed Slaughter, Weslaco—*Science* (14 articles).

Dr. George M. Waddill, Jr., Amarillo—*Milk, pasteurization and sterilization* (7 articles).

Dr. H. D. Prichard, Wichita Falls—*Amnesia* (6 articles).

Dr. O. H. Heins, Lyford—*Prostitution* (7 articles).

Dr. J. T. O'Banion, Luling—(1 journal).

Dr. A. L. Hathcock, Palestine—*Pruritus, ani* (19 articles).

Dr. Ben B. Hutchinson, Lubbock—*Eyes, foreign bodies* (17 articles); *Eyes, foreign bodies* (24 articles).

Dr. Margaret Alexander, Dallas—*Puerperium, hygiene* (6 articles).

Dr. J. W. Oxford, Floresville—*Blood, groups* (29 articles).

Dr. C. B. Batson, Lubbock—(3 journals).

Dr. E. Filmore Meredith, Olney—*Osteoarthritis* (10 articles); (9 journals).

Dr. M. E. Jacobson, Temple—*Peptic Ulcer, surgical therapy* (15 articles).

Dr. Stewart Cooper, Abilene—*Blood Transfusion, autotransfusion* (10 articles).

Dr. Charles Mims, Mission—*Urethritis* (15 articles).

Dr. Elliott Mendenhall, Dallas—*Syphilis, tuberculosis and syphilis* (11 articles).

Dr. E. H. Caldwell, Tyler—*Colon, dilatation* (15 articles).

Dr. Joseph R. Harris, Lubbock—(1 journal).

Dr. Frank B. Duncan, Amarillo—(1 book).

Dr. R. C. Stokes, Fort Worth—*Syphilis, serodiagnosis* (5 articles).

Dr. W. T. Sadler, Merkel—*Tobacco* (23 articles).

Mr. Chalmers Horton, Dallas—(3 journals).

Dr. Thomas E. Cook, Dallas—*Vertigo, aural* (18 articles).

Dr. George T. O'Byrne, Corpus Christi—*Eosinophils* (9 articles).

Dr. Robert J. Hanks, Waco—*Pleura, lavage* (3 articles).

Dr. G. Levin, Houston—*Bronchiectasis* (37 articles).

Dr. L. B. Outlar, Wharton—(1 journal); (1 journal).

Dr. M. H. Moore, Tyler—*Heart, abnormalities* (23 articles).

Dr. J. D. Magee, Jr., Abilene—*Tongue, cancer* (24 articles).

Dr. W. D. Blassingame, Denison—*Intestines, diverticula* (10 articles).

Dr. Sol B. Estes, Abilene—*Rehabilitation* (15 articles).

Dr. G. J. Hayes, Alvin—*Economics, medical* (12 articles).

Dr. Irving McNeil, El Paso—(1 journal).

Dr. S. Joe McKinsey, McAllen—(2 journals).

Providence Hospital, Waco—(1 journal).

Dr. A. L. Delaney, Liberty—*Dystrophy, muscular* (13 articles).

Dr. R. E. Lovett, Olney—*Colitis, ulcerative* (21 articles).

Dr. Ellen D. Furey, Beaumont—(2 journals).

Dr. J. P. McAnulty, San Angelo—(1 journal).

Dr. John D. Gleckler, Denison—*Impregnation* (9 articles).

Packages on compulsory sickness insurance to superintendents, debate coaches, and students in Texas high schools, 17.

ACCESSIONS

Philadelphia, Lea & Febiger—Wintrobe: Clinical Hematology; Scott and Van Wyck: The Essentials of Obstetrics and Gynecology.

Springfield, Illinois, Charles C. Thomas—Spivack: The Surgical Technic of Abdominal Operations; Spivack: Urgent Surgery; Montagu: Adolescent Sterility; Pelner: Gastroenterology in General Practice.

Baltimore, Williams and Wilkins—Goni: Myasthenia Gravis.

Philadelphia, W. B. Saunders—Daniels, Williams and Worthington: Muscle Testing.

New Haven, Hillhouse Press—Gross: Acetanilid, A Critical Bibliographic Review.

Collected Reprints of the National Foundation for Infantile Paralysis, 1945.

SUMMARY

REPRINTS RECEIVED, 756.	LOCAL USERS, 28.
JOURNALS RECEIVED, 222.	BORROWERS BY MAIL, 57.
ITEMS CONSULTED, 156.	PACKAGES MAILED, 59.
ITEMS TAKEN OUT, 123.	ITEMS MAILED, 573.

TOTAL ITEMS CONSULTED AND MAILED, 852.

MOTION PICTURE FILM LIBRARY

Motion picture films on medical subjects, 16 mm., both silent and sound, some in color, and suitable for either medical or lay audiences, are available for loan to county medical societies, hospital staffs, or individual physicians, on request. Borrowers will be required to pay only the cost of shipment of the films, by express, with insurance, and for any damage to films while in the hands of the borrower.

Requests for films should be addressed to "Motion Picture Film Library, State Medical Association of Texas, 1404 West El Paso Street, Fort Worth 3, Texas." A list of available films, with descriptions, will be furnished on request.

The following motion picture films were loaned by the Film Library of the State Medical Association of Texas during December:

Anesthesia, Regional (Available through the courtesy of Winthrop Chemical Company)—Matagorda County Medical Society and Hospital Staff, Bay City.

Appendicitis in Childhood (Available through the courtesy of Mead Johnson & Company)—Cherokee County Medical Society, Rusk, and Hospital Staff Meeting, Jacksonville.

Bleeding Tendency, Method for Determination of (Available through the courtesy of Mead Johnson & Company)—Lamar College, Beaumont.

Blood Transfusion, the Technique of (Available through the courtesy of Mead Johnson & Company)—Lamar College, Beaumont.

Breech Extraction with Forceps (Available through the courtesy of Mead Johnson & Company)—Harris College of Nursing, Fort Worth.

From Moo to You (Available through the courtesy of the Borden Company)—Arlington Public School P. T. A. and Sunset School (Negro) P. T. A., Tarrant County.

Goodbye, Mr. Germ (Available through the courtesy of the Texas Tuberculosis Association)—Foodhandlers' Sanitation School and Health Department, Fort Worth.

Let There Be Light (Available through the courtesy of the War Department)—St. Paul's School of Nursing, Dallas.

Magic Bullets (Available through the courtesy of the U. S. Public Health Service)—Emmett Scott Senior High School, Tyler, and the Medical and Allied Science Club, Tyler.

Newborn, the Resuscitation of (Available through the courtesy of Mead Johnson & Company)—Matagorda County Medical Society, Bay City, and Harris College of Nursing, Fort Worth.

Normal Delivery (Available through the courtesy of Mead Johnson & Company)—Harris College of Nursing, Fort Worth.

NEW MOTION PICTURE FOR THE FILM LIBRARY

The Motion Picture Film Library of the State Medical Association has received the following film from the National Foundation for Infantile Paralysis for relending:

A New Horizon. 16 mm., sound, showing time, 20 minutes. This motion picture was filmed by RKO-Pathe and approved by the American College of Surgeons. It depicts a complete physical therapy department and shows the way in which such a department is utilized in the modern hospital.

LIBRARY NEEDS

The journals listed below are needed by the Library of the State Medical Association to complete volumes for binding. Any of these numbers will be acceptable either as a gift or for purchase. It is preferable that physicians notify the Library, 1404 West El Paso Street, Fort Worth 3, regarding the items they have available and the prices of such items, if any, before shipping them. The numbers needed follow:

American Journal of Roentgenology, Vol. 5, No. 5 (May) 1918.

Annals of Internal Medicine, Vol. 8, No. 10 (April) 1935.

Archives of Internal Medicine, Vol. 55, No. 6 (June) 1935.

California & Western Medicine, Vol. 39, No. 3 (Sept.) 1933.

Endocrinology, Vol. 17, No. 1 (Jan.-Feb.) 1933.

Medical Record & Annals, Vol. 28, No. 7 (July) 1934.

Western Journal of Surgery, Obstetrics & Gynecology, Vol. 42, No. 12 (Dec.) 1934.

BOOK NOTES

QUARTERLY REVIEW OF OBSTETRICS AND GYNECOLOGY

Publishers of the *Quarterly Review of Obstetrics and Gynecology* have announced the availability of a limited edition of the first three volumes of the journal, which have been reprinted and permanently bound so that physicians who were in military service or otherwise unable to subscribe to the *Quarterly Review* from its first issue might now complete their files. These three volumes contain 3,663 abstracts of noteworthy articles on the subjects of obstetrics and gynecology published in the world's medical literature during 1943, 1944, and 1945. The three-volume sets at $25 per set may be obtained from the Washington Institute of Medicine, 1720 M Street, N. W., Washington 6, D. C.

[1]**The Venous Pulse and Its Graphic Recording.** By Franz M. Groedel, M. D., Attending Cardiologist, Beth David Hospital; Cardiologist, St. Anthony's Hospital; Consulting Cardiologist, Einhorn Department, Lenox Hill Hospital, New York. Cloth, 216 pages, with 7 illustrations and 290 tracings on 114 figures. Price, $5.50. New York, N. Y., Brooklyn Medical Press, 1946.

This small book is an outgrowth of an article, previously published by Groedel, discussing the venous pulse and the phlebogram. The book is divided into four sections and an extensive bibliography. Groedel believes that the pneumocardiogram has proved its importance in the interpretation of the phlebogram and hence has a section on the pneumocardiogram. The third section describes the esophago-cardiogram. There is also a section, occupying about one-third of the book, devoted to illustrations of the representative phlebograms, esophago-cardiograms, and pneumocardiograms.

The book has value as a reference text, and probably should be accessible to physiologists and research workers interested in cardiac hemodynamics. The text is very repetitious. The illustrations are excellent. I doubt Groedel's conclusion that "these techniques will and should be practiced by every cardiologist and clinic." I am in agreement that phlebography is a valuable method for research and may yield further knowledge of the venous pulse, and therefore become a research method of examining disordered hearts.

[2]**A Textbook of Gynecology.** By Arthur Hale Curtis, M. D., Professor and Chairman of the Department of Obstetrics and Gynecology, Northwestern University Medical School; Chief of Gynecological Service, Passavant Memorial Hospital, Chicago. Fifth edition. Cloth, 755 pages, with 401 illustrations, including 36 in color. Price, $8.00. Philadelphia and London, W. B. Saunders Company, 1946.

This is a most comprehensive, yet succinct, presentation of the subject of gynecology. As stated in the preface to the fifth edition, the work has been thoroughly revised and many portions have been rewritten on account of recent advances and discoveries. While any author who endeavors to confine between the covers of one volume the entire field of gynecology suffers for want of space, the work has achieved this goal as well as any written up to the present time. A system of two or three volumes would do greater justice to such a thorough and painstaking author and teacher. Nevertheless, it is a remarkable compendium of the facts to date and

[1]Reviewed by Alfred W. Harris, M. D., F. A. C. P., Dallas.
[2]Reviewed by Allen T. Stewart, M. D., Lubbock.

should be valuable both to the practitioner and to the student.

The greatest single merit of the work is its illustrations. Practically all are the original work of the author. The master hand of Tom Jones is seen in many of the drawings. The photographs and microphotographs are clear and distinct. Any student or specialist can get a graphic and instructive picture of the subject of gynecology from the perusal of the illustrations alone. No better work, outside special atlases, has ever been presented.

Space does not permit a full discussion of all portions of the work. Suffice it to say that no gynecological problem or entity is neglected or omitted. The literature of gynecology has received an important contribution. The author is an original thinker and teacher as well as a master in compiling the work and research of contemporaries. It is commended to all for study and reference.

[3]**Gastro-Enterology** (in three volumes). Volume III. By Henry L. Bockus, M. D., Professor of Gastro-Enterology, University of Pennsylvania Graduate School of Medicine, and Colleagues at University of Pennsylvania Graduate School of Medicine. Cloth, 1,091 pages, fully illustrated, many in colors. Price, $35.00 per set. Philadelphia and London, W. B. Saunders Company, 1946.

Volume III is indeed a worthy companion of Volumes I and II. This volume deals with the liver, biliary tract, pancreas, parasites of the gastro-intestinal tract, and the effects on the gastro-intestinal tract of associated diseases.

In the production of this volume, Bockus has had the able assistance of fourteen associates of the Faculty of the University of Pennsylvania Graduate School of Medicine.

I can speak only in terms of highest praise of this volume. The section on diseases of the liver and biliary tract is presented brilliantly. The discussion of liver function tests is sufficiently brief and yet comprehensve. In fact, each chapter is presented in a "fresh as a daisy" fashion. Sufficient reference is made to an extensive bibliography, without becoming tiresome.

Apparently Bockus, with his profoundly scientific, and yet practical clinical turn of mind, has influenced his associates in such a way that one may hardly discern whether a given chapter is being presented by Bockus or one of his associates without referring to the chapter title. The discussion of duodenal-biliary drainage in relation to diseases of the biliary tract, especially from the standpoint of diagnosis, is presented in a clear, comprehensive, and unbiased manner. In the same way, the chapter on visceroptosis, which I think the average clinician would feel might be dismissed with a few simple statements, is presented in a well balanced manner. One has the feeling that here two topics have been called up and reevaluated with such clarity that no practicing physician would wish to ignore this presentation.

The part of this volume dealing with secondary affections of the gastro-intestinal tract is a helpful and practical section. The chapters on Functional Disorders of the Gastro-Intestinal Tract of Neuropsychiatric Origin; Gastro-Intestinal Allergy; Inter-Relationship of Cardiac and Gastro-Intestinal Disorders; Digestive Tract Symptoms Secondary to Pulmonary Tuberculosis; and Digestive Tract Symptoms Secondary to Genito-Urinary Diseases, are all presented by writers who have had not only scholarly training and association, but who are also clinicians with extensive experience.

There are other interesting and informative chapters.

In viewing the tremendous scope, not only of gastro-enterology, but of internal medicine, which these three volumes have covered, I have a feeling of genuine gratitude to Bockus and his associates. This treatise is, in a way, encyclopedic in nature. It will for years to come be one of the corner stones of gastro-enterology, and every internist will find it a delightful reference.

[3]Reviewed by George M. Underwood, M. D., Dallas.

[4]**Renal Hypertension.** By Eduardo Braun-Menendez, Juan Carlos Fasciolo, Luis F. Lelior, Juan M. Munoz, and Alberto C. Taquini. Translated by Lewis Dexter, M. D. Cloth, 451 pages. Price, $6.75. Springfield, Illinois, Charles C. Thomas, Publisher, 1946.

The publication of Goldblatt's classic experiment in 1934 made possible the production of experimental hypertension and demonstrated that this condition was independent of the excretory function of the kidney. Since then, a vast literature has accumulated which has broadened our concepts concerning the pathogenesis of hypertension. Among the most prolific contributors to this field have been the workers in the laboratory of Professor Bernardo A. Houssay at the Institute of Physiology in Buenos Aires. The present volume is a translation of the book of these South American workers which originally appeared in Spanish in 1943. The book covers in detail all of the researches of the South American school and discusses the relation of these studies to the work in other laboratories as well as to their bearing on the general subject of hypertension. It is, therefore, an excellent review of research in this field and will be indispensable to all who are actively engaged in the experimental study of this problem. However, it cannot be recommended to the uninitiated or to those who have been actively engaged in this work, since the fundamental concepts upon which most of the discussion is based have been largely discredited in recent years.

Most authorities, including the South American workers, now realize that the available facts contradict the view, formerly generally held, that a pressor substance (renin, angiotonin, or hypertensin) plays any part in the pathogenesis of chronic hypertension. Undoubtedly, if the South American workers were to rewrite their volume today, their approach to the problem would be entirely different. Rapid developments in this field have unfortunately rendered much of the material in the book obsolete. Nevertheless, it is a useful summary of the earlier work in this field. The complete bibliography, which includes 1,238 titles, will be particularly useful to the experimentalist interested in hypertension.

[5]**Through the Stratosphere.** The Human Factor in Aviation. By Maxine Davis. Cloth, 253 pages. Price, $2.75. New York, The Macmillan Company, 1946.

This is a newspaper woman's record of the evolution and use of a great number of devices utilized by the air forces for keeping fliers healthy, happy, and in the air. It is a resume of her flight during World War II, and also a good record of what aviation medicine has accomplished for the modern flier. Miss Davis has travelled half across the earth to collect these facts, to see these devices at work and the men who used them.

The introduction takes the reader to Wright Field, Dayton, Ohio, and other research points, including the School of Aviation Medicine at Randolph Field, Texas, a C-54 transport trip to Europe over the Alps, the oil fields of Ploesti, and on into India, "over the Hump" into China and then to Ceylon, with a return trip by way of the great African desert to Casablanca, the Azores, and Bermuda. During this trip the author lived at least eighteen hours a day with pilots, navigators, radio operators, and gun-

[4]Reviewed by Arthur Grollman, M. D., Dallas.
[5]Reviewed by T. J. Cross, M. D., Fort Worth.

ners. She talked, ate, drank, and flew with generals, sergeants, privates, flight surgeons, and flight nurses, from whom she received much official information. Miss Davis attempts to explain the devices and mechanisms used in aviation medicine. She gives a graphic description of the flier and his training. Her eulogy of the flght surgeon, "a kind of Chinese doctor extensively and intensively trained to keep men well," is very good.

Section two is a minute description of the selection and training of the pilots which is comparable to the advancement in aircraft itself. In February, 1919, at the Inter-Allied Conference of Flight Surgeons, which was held in Rome, a number of requirements for pilots were agreed upon. In 1939 the Civil Aeronautics Authority instituted some studies on these requirements, the author states, although as late as 1941 the Army Air Forces were not agreed on the standards regarding physiological studies. However, I have been making rigid physical examinations for the Civil Aeronautics Authority since 1927.

Sections three and four describe the personal feelings and reactions of the flier and his crew in going about their work and combat. The fifth section has to do mostly with personalities of several individual fliers and their reaction to combat fatigue. In conclusion, the last section is an appreciation of the nurses of the sky, the wounded who came home, and the teamwork in getting them well.

[6]**Roentgen Diagnosis of Diseases of the Gastro-intestinal Tract.** By John T. Farrell, Jr., M. D., Clinical Professor of Radiology, Graduate School of Medicine, University of Pennsylvania; Radiologist, Herman Hessenbrugh Memorial Department of Radiology, the Lankenau Hospital. Cloth, 271 pages. Price, $5.50. Springfield, Illinois, Charles C. Thomas, Publisher, 1946.

This is a manual which is the combined result of the author's experience in lecturing to graduate medical students in roentgenology, and the accumulation of a goodly number of illustrative roentgenograms. The book contains 190 clear reproductions of roentgenograms with concise descriptions. Also, in addition to descriptions of technique, there are discussions of physiology of motility. In this book, pathologic conditions which may be recognized by x-ray investigation are considered under each of the major divisions of the gastro-intestinal tract. As a guide, the notes are based on classifications outlined in "Standard Nomenclature of Disease," edition 3, 1942.

This book should be of much use to the physician who really wants to develop in himself a critical approach to gastro-intestinal x-ray studies.

[6]Reviewed by F. W. Halpin, M. D., Fort Worth.

NEWS

Contributions to this department will be appreciated. News should be of general medical interest, such as public health activities, new hospitals, personal items of more than local value, etc. News for a particular number of the JOURNAL should be in the hands of the Editor not later than the fifteenth of the preceding month.

Southwestern Medical Association—Approximately 250 physicians from Texas, New Mexico, Arizona, and Mexico were in El Paso, November 14-16 for a meeting of the Southwestern Medical Association. New officers elected to serve during the next year include Dr. J. W. Hannett, Albuquerque, president; Dr. Leslie M. Smith, El Paso, president-elect; Dr. Thomas Bate, Phoenix, first vice-president; Dr. I. J. Marshall, Roswell, second vice-president; and Dr. Louis W. Breck, El Paso, secretary-treasurer. The next meeting will be in Phoenix, Ariz., the latter part of October.

El Paso County Medical Society and Auxiliary entertained at several social functions for the visitors, whose main attention was focused on a scientific program presented by outstanding physicians from throughout the country: Drs. Nelson W. Barker and Paul O'Leary, Rochester, Minn.; William C. Deamer, San Francisco; Michael E. De Bakey, New Orleans; William F. Mengert, Dallas; Charles T. Stone, Galveston; and Palmer E. Wigby, Houston.

The New Orleans Graduate Medical Assembly will hold its tenth annual meeting in New Orleans, February 24-27, with a roster of eighteen distinguished physicians as guest speakers. The registration fee of $15, which covers three round-table luncheons, lectures, clinics, symposia, technical exhibits, and other features, should be sent to the Assembly, 1430 Tulane Avenue, New Orleans 13.

The National Physicians Committee was host at a luncheon December 11 at the Drake Hotel, Chicago, for officers and members of the House of Delegates of the American Medical Association. Dr. Edward H. Cary, Dallas, chairman of the National Physicians Committee, presided and was paid tribute by Dr. Harrison Shoulders, Nashville, Tenn., president of the American Medical Association. The main address was delivered by W. A. Patterson, Chicago, president of the United Airlines, who discussed "Private Enterprise."

Post Graduate Medical Assembly of South Texas elected directors on December 5, the last day of its recent meeting in Houston. The following directors were chosen: Eighth District—Drs. Vernon Black, Wharton; C. I. Shult, Columbus; C. C. Guenther, La Grange; Frank Wagner, Shiner; Ninth District: Drs. T. J. Blocker, Galveston; Marius Hansen, Washington; L. E. Bush, Huntsville; H. L. Steward, Navasota; J. E. Clarke, Mylie E. Durham, Cornelius Pugsley, M. B. Stokes, E. Trowbridge Wolf, Byron P. York, all of Houston; Tenth District—Drs. J. A. Bybee, Beaumont; G. H. Fahring, Anahuac; L. H. Ledbetter, Beaumont; W. J. Poshataske, Silsbee; A. R. Shearer, Mont Belvieu; A. E. Sweatland, Lufkin. Dr. Byron P. York, Houston, was installed as new president of the assembly, the Houston *Post* informs. The board of directors will meet in January to elect other officers for the 1947 assembly.

The Dallas Academy of Medicine held its first annual banquet December 16 in the Crystal Ballroom of the Baker Hotel, Dallas, to celebrate its founding last June and its successful sponsorship of the Dallas Health Museum, opened to the public for the first time during October, reports the Dallas *Times Herald.* Chauncey D. Leake, Ph. D., vice-president and dean of the University of Texas Medical Branch, Galveston, spoke, and a two-hour floor show of Southwest talent was presented.

Providence Hospital, Waco, has been conducting a drive to raise $200,000 to $250,000 from the people of Waco, with the understanding that the Sisters of Charity of Saint Vincent de Paul, who have operated the hospital from their own funds since 1903, will match the sum subscribed and that the federal government will contribute an equal amount, reports the Waco *Tribune-Herald.* It is estimated that Waco needs six times as many hospital beds as are now available, and funds secured in the current campaign will provide one hundred more beds, a diagnostic clinic, and other facilities, which will be erected late in 1947, when it is anticipated building materials will be more readily available. Physicians of the McLennan County Medical Society adopted a resolution in support of the Providence Hospital project and pledged $50,000 toward the goal.

The Cameron Hospital, founded in 1914 by the late Dr. W. R. Newton and Dr. Eduard Rischar in Cameron, and since 1940 the sole property of Dr.

Rischar, has been donated by Dr. Rischar to the Sisters of the Incarnate Word of the diocese of Galveston so that the work of the hospital may be perpetuated for the benefit of the people of Cameron and the surrounding area, informs the Cameron *Enterprise*. The name of the hospital is being changed to St. Edwards Hospital. Sixteen other hospitals and orphanages are operated in Texas and throughout the United States by the Sisters of the Incarnate Word. Dr. Rischar will continue to have his office in the hospital.

The Bowie Clinic, Bowie, now occupies a new building connected with the old structure, which will be devoted entirely to hospital space, according to the Bowie *News*. Drs. E. P. Harris, E. W. Wright, J. T. Lawson, V. J. Donnelly, Prentice Crumpler, H. P. Crumpler, C. J. Dodsworth, and other members of the clinic staff have moved from their previous crowded quarters into the new building. Changes and improvements will be made in the hospital building.

The Veterans Administration Hospital at **Legion** has recently secured an "aluminum lung," states the Kerrville *Sun*. This modern adaptation of the iron lung weighs only about fifty pounds and is designed for use in automobiles, trains, or airplanes as well as for hospitals.

University of Houston officials are considering plans for charging a compulsory medical fee to finance a full-time medical staff composed of at least one physician and two nurses, according to the Houston *Post*. The university now employs a part-time physician to give physical examinations to entering students and to serve the football team. Dr. E. E. Oberholtzer, president, says that hardly a day passes that emergency medical aid is not needed for the students and that he is recommending the more comprehensive program to the board of regents.

A **Home Nursing Course** has been made compulsory for senior girls at Garland High School, the Garland *News* reports. Taught by a graduate nurse, the course is a combination of lectures, textbook study, and student demonstrations, and each class receives two hours of instruction per week. Upon completion of the course students will be qualified to assist in hospitals as well as in their own homes.

Plainview Crippled Children's Clinic.—A clinic for crippled children, particularly the victims of poliomyelitis, was held in Plainview on November 30 with Dr. Sim Driver and Dr. Eugene P. Legg, Dallas, in charge, states the Crosbyton *Review*.

Mental Hygiene Meetings.—Houston, Dallas, El Paso, San Antonio, Lubbock, Corpus Christi, and Austin have been hosts recently to experimental psychiatry institutes sponsored by the Texas Society for Mental Hygiene, the Hogg Foundation, and the Red Cross, according to the Houston *Chronicle* and Houston *Post*. Dr. C. S. Bond, associate psychiatrist of the Houston Bureau of Mental Hygiene, was the speaker when forty Red Cross case workers from eighteen Southeast Texas counties met in Houston in November.

Dr. Herbert E. Chamberlain, consultant psychiatrist with the California State Department of Social Welfare, spoke at a three-day institute in Abilene in November under the sponsorship of the Abilene-Taylor County chapter of the Texas Society for Mental Hygiene.

Cancer Control Program.—Corpus Christi has been chosen as a cancer treatment center with operation to begin early in 1947, announces J. Louis Neff, Houston, executive director of the Texas Division of the American Cancer Society. The announcement, reported in the Corpus Christi *Caller* following a meeting of the local members of the American Cancer Society and the Nueces County Medical Society, indicated that location of the center in Corpus Christi was made possible because of the generous donations of citizens of that community during a statewide drive for funds last April. Plans were made to set up a central committee composed of a physician specializing in cancer, a layman to raise necessary funds, and a woman to lead the education program.

The M. D. Anderson Hospital for Cancer Research Auxiliary and the Texas Division of the American Cancer Society have coordinated their programs in Houston, reports the Houston *Post*. Among the activities proposed are an expansion of the blood bank, provision of housing facilities for patients under treatment for cancer but not requiring hospitalization, the establishment of recreation services for patients, preparation of surgical dressings, the establishment of a loan service to supply sick room and hospital necessities to patients, and expansion of the popular education program. Dr. E. W. Bertner, president of the Texas Medical Center; Dr. R. Lee Clark, director of the Anderson Hospital; J. Louis Neff, executive director of the Texas Division of the American Cancer Society; and Mrs. Herbert L. Flake, chairman of the M. D. Anderson Auxiliary, spoke at a luncheon meeting in November.

Phi Chi Benefit Association has announced receipt from H. R. Cullen, Houston oil man, of a $10,000 gift and a promise of help toward erection of a new fraternity home near the Texas Medical Center in Houston, reports the Houston *Chronicle*. The gift was made in a drive which the medical fraternity has been conducting to help clear the mortgage from its present home in Houston and to finance lectureships, scholarships, and better library facilities.

Dr. Chapman Reynolds, professor of medicine at Louisiana State University; and Dr. A. C. Broders, Rochester, Minn., have already lectured in Houston this season under sponsorship of the fraternity, and Drs. R. Cattell, Boston; George Simonds, Northwestern University, Evansville, Ill.; Lester Dragstedt, University of Chicago; and Milford Rouse, Southwestern Medical College, Dallas, are scheduled to appear in Houston before summer.

Texas Medical Center.—All bids received by the Texas Medical Center for paving and installation of utility lines have been rejected by the board of trustees because they far exceeded estimated costs of $212,000, informs the Houston *Post*.

A donation of $100,000 toward construction of a Methodist Hospital to be erected in the Texas Medical Center has been made by Mr. and Mrs. Walter Goldston, Houston. Mr. Goldston, an independent oil operator, is chairman of the new hospital's building campaign, the Houston *Chronicle* indicates. Previous donations toward the proposed three hundred bed structure have included $1,000,000 from H. R. Cullen, Houston, and $500,000 and the building site from the M. D. Anderson Foundation.

Southwestern Medical College has recently received three substantial grants for research, the Dallas *News* reports. The National Foundation for Infantile Paralysis donated $9,575 for conducting investigations on the influence of anesthesia on the course and outcome of experimental neurotropic virus infections under the direction of Dr. S. Edward Sulkin, chairman of the Department of Bacteriology and Immunology. Research concerning the clinical and therapeutic action of penicillin and streptomycin, also under Dr. Sulkin's direction, received a grant of $2,340 from the U. S. Public Health Service. The First Texas Chemical Manufacturing Company, with headquarters in Dallas, has contributed $5,000 for research in pharmacology.

The Texas Branch of the Society of American Bacteriologists held its biannual meeting at Southwestern Medical College on November 16 with some one hundred physicians and bacteriologists from Texas and the Southwest in attendance, the Dallas *News* reports.

Dr. E. G. Faber, Tyler, has been named assistant professor of medicine at Southwestern Medical College, according to the Tyler *Courier-Times*. Dr. Faber lectures in Dallas once a week.

Dr. Arthur Grollman, professor of medicine at Southwestern Medical College, was speaker December 2 for the American Broadcasting Company program "Doctors Talk It Over," informs the Laredo *Times*.

University of Texas.—Dr. Jack R. Ewalt, professor of neuropsychiatry at the University of Texas Medical Branch, was named vice-president of the Central Neuropsychiatric Association in Denver, October 4-5, according to *The Journal of the American Medical Association*.

Dr. Mary E. Sauer, assistant professor of anatomy at the University, was an honored guest and commencement speaker for William Jewell College, Liberty, Mo., in November, the Galveston *Tribune* reports. Dr. Sauer, an alumna of the college, also made a series of informal talks to students and graduates.

Chauncey D. Leake, Ph. D., dean and vice-president of the University of Texas Medical Branch, was one of the principal speakers at a celebration of the centennial of the discovery of ether held by the Chicago Institute of Medicine in November, according to the Galveston *Tribune*.

Dr. Ludwik Anigstein, professor of geographic medicine, and Dr. Charles M. Pomerat, professor of cytology, participated in the annual meeting of the American Association for the Advancement of Science in Boston, December 26-31, the Galveston *Tribune* states. They were invited to report before the section on medical science the results of studies on anti-organ immune sera which they began about two years ago. Dr. Pomerat has also been invited by the division of medical sciences of the National Research Council to be one of thirty-two scientists from throughout the United States and Europe to discuss how tissue culture methods may help in the general attack being planned by the committee on growth to solve the cancer problem.

Three new appointments at the University have been announced through the Galveston *News* and *Tribune*. Dr. Wicktor Nowinski, formerly of London and more recently of Buenos Aires, will be a research associate in the tissue culture laboratory. Dr. Frederick McCoy, who has just been released from military service, will be resident physician in plastic surgery at John Sealy Hospital. Dr. Hilburn D. Gilliam, a graduate of the University of Texas School of Medicine who has been in the Navy until recently, has been named assistant resident in radiology.

Personals

Dr. W. Compere Basom, El Paso, has been elected to membership in the American Academy of Orthopedic Surgeons, reports the El Paso *Herald-Post*.

Dr. Burke Brewster, health and welfare director of Fort Worth since 1939, resigned his position effective January 1 to do postgraduate work in New York and then return to private practice in Fort Worth, according to the Fort Worth *Press*.

Dr. F. E. Sadler, formerly physician in a Veterans Administration Hospital at Sulphur Springs, Okla., became director of the Howard-Midland-Ector Counties health district on January 1, succeeding *Dr. James R. Turner*, reports the Odessa *American*.

Dr. Jack A. Crow was elected 1947 chief of staff of St. Ann's Hospital, Abilene, at a recent dinner meeting attended by hospital officials and staff physicians, informs the Abilene *Reporter-News*. *Dr. J. C. Duff* was chosen vice-chairman; *Dr. F. W. Bailey*, secretary; *Dr. George D. Thurman* and *Dr. R. W. Varner*, members of the executive committee for two years.

Drs. Gordon Madding and *W. D. Anderson*, San Angelo, spoke at a district medical society meeting in Hobbs, N. M., in November, according to the San Angelo *Standard-Times*.

Dr. James A. Hunter, Jr., graduate of the University of Texas School of Medicine and former intern at John Sealy Hospital, Galveston, will participate in the Navy's antarctic expedition under the command of Admiral Richard E. Byrd, the Galveston *Tribune* states. Dr. Hunter, a member of the U. S. Public Health Service staff, had been stationed at the Marine Hospital in Galveston before receiving orders recently to report for the antarctic assignment.

Dr. Harriet Rogers, who has been in practice at Commerce since 1941 and has served as secretary-treasurer of the Hunt-Rockwall-Rains Counties Medical Society the past two years, has accepted a position on the medical staff of the Florida State College for Women in Tallahassee, reports the Commerce *Journal*.

Dr. Clinton E. Adams, Abilene, recently took a refresher course at Knickerbocker Hospital, New York City, studying diagnosis and treatment of poliomyelitis. His expenses were paid by the Taylor County chapter of the National Foundation for Infantile Paralysis, of which Dr. Adams is a medical adviser, according to the Abilene *Reporter-News*.

Dr. James A. Abney, retired Brownwood physician, was honored on his one hundredth birthday November 6 with a family reunion and the night before by a tribute arranged by the local post of the American Legion, according to the Brownwood *Bulletin*. Dr. Abney, last surviving Confederate veteran in Brown County, received congratulatory messages from President Harry Truman, Governor Coke Stevenson, Fleet Admiral Chester Nimitz, General Jonathan M. Wainwright, and many others.

Dr. Claudia Potter, head of the department of anesthesia at Scott and White Hospital, Temple, was honored on her fortieth anniversary of service with the hospital at a dinner November 14 given by senior staff members of the hospital, reports the Temple *Telegram*. Dr. Potter has been on the hospital staff longer than any other of its present members.

Dr. W. A. Ramsay, Joaquin physician for about fifty years, celebrated his seventy-seventh birthday November 8 at a dinner for relatives and friends arranged by Mrs. Ramsay, the Center *Champion* states.

Dr. P. A. Rogers, Dallas, was robbed of $19,800 in November by a bandit who took his billfold and left Dr. Rogers bound by his own belt and shoe laces on the floor of his office, the Dallas *News* reports.

Marriages

Dr. Stewart R. M. Long, Temple, married Miss Nita Hewell, Atlanta, Ga., on September 6.

Dr. William S. Brumage and Miss Mary Virginia Wiggins, both of Austin, were married in Austin on December 21.

Births

To *Dr. and Mrs. Fred M. Hammond, Jr.*, Temple, a daughter, Lynda Kay, on November 12.

To *Dr. and Mrs. David Eanes*, Temple, a daughter, Judith Carol, on September 25.

To *Dr. and Mrs. W. P. Higgins, Jr.*, Fort Worth, a son, Charles Michael, on November 6.

To *Dr and Mrs. Robert C. Barker*, Fort Worth, a son, Edward R., on October 27.

SOCIETY NEWS

Bastrop County Society

(Reported by C. M. Hoch, Jr., Secretary)

Bastrop County Medical Society has recently elected the following officers: J. D. Stephens, Smith-

ville, president; Joe V. Fleming, Elgin, vice-president; and C. M. Hoch, Jr. Smithville, secretary. J. G. Bryson, Bastrop, is delegate and Joe V. Fleming, Elgin, is alternate. Members of committees include J. G. Bryson, Bastrop; C. M. Hoch, Jr., Smithville; and Joe V. Fleming, Elgin, medical and hospital committee; F. J. Kroulik, Smithville; W. E. Woods, Elgin; and J. D. Stephens, Smithville, board of censors; and J. G. Bryson, Bastrop; Joe V. Fleming, Elgin, and J. D. Stephens, Smithville, legislative committee.

Brazoria County Society

December 12, 1946

(Reported by A. O. McCary, Secretary)

Members of the Brazoria County Medical Society, dentists, and the auxiliaries met at the Dow Chemical Company Cafeteria, Freeport, on December 12 for dinner and a business meeting.

Officers elected to serve the medical society for 1947 are as follows: Herbert E. Merz, Alvin, president; W. T. Galloway, Freeport, vice-president; A. O. McCary, Freeport, secretary-treasurer; W. M. Greenwood, West Columbia, delegate; S. B. Slaughter, Freeport, alternate delegate; George D. Reeves and R. M. McCary, Freeport, and Herbert E. Merz, Alvin, board of censors.

H. K. May, of the Dow Magnesium Corporation Hospital, and C. E. Fuste, Jr., Alvin, were introduced as new members.

Brown-Comanche-Mills-San Saba Counties Society

November 11, 1946

Low Back Pains with Both Psychiatric and Neurological Implications—Melvin W. Thorner, San Antonio.
Commoner Diseases of the Ano-Rectal Region—Carl G. Giesecke, San Antonio.

Two San Antonio physicians were speakers for the November 11 meeting of the Brown-Comanche-Mills-San Saba Counties Medical Society held in Hotel Brownwood. Thirteen physicians heard Melvin W. Thorner and Carl G. Giesecke discuss the subjects named above.

Dallas County Society

December 12, 1946

Dallas County Medical Society on December 12 elected John G. Young president. Edward White was named to the new position of president-elect and will become president in 1948. Other officers include Howard Shane, vice-president; W. W. Fowler, secretary-treasurer (reelected for his twenty-eighth term); Edward White, Hall Shannon, David W. Carter, and G. E. Brereton, delegates; B. E. Parks, Jack G. Kerr, A. B. Small, Ridings E. Lee, and Robert F. Short, alternates; and J. L. Goforth, censor.

Dawson-Lynn-Terry-Gaines-Yoakum Counties Society

December 11, 1946

(Reported by A. H. Daniell, Secretary)

Intussusception-Reduction by Barium Enema—Sam C. Arnett, Lubbock.

Following presentation of the paper named above, Dawson-Lynn-Terry-Gaines-Yoakum Counties Medical Society in session at Tahoka on December 11 named the following officers for the coming year: L. E. Standefer, Lamesa, president; A. H. Daniell, Brownfield, vice-president and president-elect; G. W. Gerardy, Seagraves, secretary-treasurer; S. Z. Frazier, Lamesa; A. L. Bradford, Seminole; and F. P. Miller, Brownfield, board of censors; J. C. Loveless, Lamesa, delegate; and N. H. Price, Lamesa, alternate.

The society voted to meet the second Wednesday of every month, alternating between Tahoka, Brownfield, Lamesa, Seminole, and Seagraves.

El Paso County Society

December 13, 1946

El Paso County Medical Society entertained with a cocktail party December 13 at the Turner Memorial Home. Those in the receiving line included Russell Holt, president of the society; Mrs. S. J. Gaddy, president of the auxiliary; John Morrison, president-elect of the society, and Mrs. Morrison; Mrs. Arthur Black, president-elect of the auxiliary, and Dr. Black.

Mesdames Orville Egbert, George M. Edwards, Hervey Dietrich, and A. D. Long were in charge of arrangements.

Falls County Society

November 12, 1946

Frank McKinley, Marlin, was principal speaker for the dinner meeting of Falls County Medical Society on November 12 at the Falls Hotel, Marlin. A. E. von Tobel was program chairman.

December 9, 1946

(Reported by J. W. Torbett, Sr., President)

Officers for 1947 were elected by Falls County Medical Society on December 9. Chosen to serve are J. W. Torbett, Sr., president; G. H. Hampshire, vice-president; Neil Buie, Jr., secretary; Howard O. Smith, alternate delegate; Tom Glass, censor. M. A. Davison, elected last year for a two-year term, will be the delegate. The new president appointed N. D. Buie, Sr., E. P. Hutchings,, and M. A. Davison to the legislative committee. All officers and committeemen are residents of Marlin.

Grayson County Society

December 2, 1946

Grayson County Medical Society elected officers at its annual dinner meeting December 2 at Hotel Denison in Denison. Herman Klapproth, Sherman, was elected president; D. K. Jamison, Denison, reelected vice-president; Don Freeman, Denison, reelected secretary-treasurer; W. A. Lee, Denison, delegate; and Arthur Gleckler, Sherman, alternate.

Committee reports for the past year were given by M. R. Woodward, Sherman, legislation and public health; W. A. Lee, public relations; Herman Klapproth, research and cancer; Don Freeman, constitution and by-laws.

Henderson County Society

December, 1946

(Reported by Don Price, Secretary)

Members of the Henderson County Medical Society were guests of the auxiliary at a buffet supper in December at the home of Dr. and Mrs. Don Price, Athens. Following the meal, the society elected officers as follows: R. E. Henderson, president; L. L. Cockereli, vice-president; Don Price, secretary-treasurer; N. D. Geddie, delegate; and J. A. Rosenbloom, alternate. Athens is the residence of all new officers except Dr. Rosenbloom, who lives in Trinidad.

Hunt County Society

November 26, 1946

Unanimous endorsement of organization of the Greenville Industrial Development Fund was voted by Greenville members of the Hunt County Medical Society in a called luncheon meeting at the Washington Hotel, Greenville, November 26. Members of the steering committee of the newly established foundation were present to answer questions.

Jefferson County Society

November 12, 1946

(Reported by L. R. Byrd, Jr., Secretary)

Clinical Pathological Conference: Presentation of Case—H. B. Williford, Beaumont.
Survey of the Present Status of Consideration of Cardiovascular Diseases and Their Treatment.—Seab J. Lewis, Beaumont.

Jefferson County Medical Society met at Hotel

Dieu, Beaumont, November 12, with President George Sladczyk, Port Arthur, presiding.

H. B. Williford, Beaumont, presented a case for clinical-pathological discussion, which was participated in by eleven members. Seab J. Lewis, Beaumont, spoke on cardiovascular diseases. His paper was discussed by J. C. Crager, Beaumont, and L. T. Pruit, Beaumont.

An amendment to the by-laws which would create an adjudication committee, discussed by E. C. Ferguson and Hugh E. Alexander, Beaumont, and R. Ray Orrill, Port Arthur, was defeated in a secret vote, 24 to 22.

Upon motion by L. C. Heare, Port Arthur, reporting for the legislative committee, and seconded by L. C. Powell, Beaumont, the society adopted a resolution urging passage by the Fiftieth Legislature of a basic science bill and a revised medical practice act bill.

Sam J. Fertitta, Jr., Edmund D. Jones, and William J. Strozier, all of Beaumont were elected to membership upon application.

Letters from Holman Taylor, Secretary of the State Medical Association, pertaining to a change in the fiscal year of the Association and announcing the time and place of the 1947 annual session were read.

President Sladczyk appointed W. E. McRee, Port Arthur, chairman of a committee to arrange for the annual banquet of the society and directed him to select other members of his committee.

The board of directors of Jefferson County Medical Society in a called meeting at Hotel Dieu, Beaumont, on November 12, discussed the newly created office of executive secretary and prospective applicants for the position. It was decided to postpone selection of the executive secretary until a secretary-treasurer for 1947 has been elected. Upon motion by L. R. Byrd, Jr., Port Arthur, seconded by L. C. Heare, Port Arthur, salary for the new position was set at $40 per month.

Kaufman County Society

December 3, 1946

(Reported by D. H. Hudgins, Delegate)

Kaufman County Medical Society, meeting December 3, elected the following officers for 1947: A. Y. Jennings, Mabank; William de Vlaming, Kaufman, vice-president; E. I. Hall, Kaufman, secretary-treasurer; D. H. Hudgins, Forney, delegate; George M. Powell, Terrell, alternate delegate; Gough Alexander, Terrell, censor (three years).

The meeting was held at the Terrell State Hospital with Dr. and Mrs. A. D. Patillo and other members of the staff hosts to physicians and their wives for a banquet. L. W. Johnston was toastmaster.

Representative and Mrs. Phillip Willis and Senator and Mrs. James Taylor were guests at the banquet. Representative Willis spoke briefly, pledging his support of the medical profession in the coming session of the Legislature.

Dr. Patillo showed motion pictures of the Pacific islands where he was stationed during the war.

Lubbock County Society

November 5, 1946

(Reported by M. H. Benson, Secretary)

Vaginal Cysts—Joseph Harris, Lubbock.
The Milk Problem in Lubbock—J. W. Rollo, Lubbock.

A resolution urging passage by the next legislature of a basic science bill and of a bill setting up professional boards for the various healing arts was adopted unanimously by twenty-six members of Lubbock County Medical Society meeting November 5 at the Plains Clinic, Lubbock.

For the scientific program Joseph Harris, Lubbock, reviewed the literature on vaginal cysts and reported on a case. There was general discussion from the floor. J. W. Rollo, Lubbock health officer, reported that Lubbock is short about 1,500 gallons of graded milk daily. As a result ungraded pasteurized milk is being sold. He indicated that the situation is slowly improving and should result in all graded milk by April, 1947.

Upon motion by Allen T. Stewart, seconded by Sam G. Dunn, both of Lubbock, it was unanimously agreed to hold a ladies night and banquet at the December meeting. Pauline Miller, chairman, and Clarence Mast were appointed to arrange for the banquet, with the program committee in charge of entertainment.

The invitation of J. A. Chatman for the society to hold its January meeting at the Negro hospital was accepted.

M. M. Ewing, O. R. Hand, and E. L. Hunt all of Lubbock, were appointed to a nominating committee.

Various communications were read. A letter from Oza La Barge, Lubbock, cited the need of the Veterans Administration for physicians. The State Public Relations Committee wrote regarding establishment of preceptorship and adjudication committees. Other letters from the State Medical Association concerned the proposed basic science and medical practice act bills and a change in the fiscal year of the Association.

December, 1946

(Reported by M. H. Benson, Secretary)

Officers of the Lubbock-Crosby Counties Medical Society were elected at the December meeting. Pauline Miller will serve as president; R. C. Douglas as vice-president; O. R. Hand as secretary; and J. W. Rollo as censor. All are Lubbock residents. Election of a delegate was deferred until January.

Nolan-Fisher-Mitchell Counties Society

(Reported by S. F. Supowit, Secretary)

Nolan-Fisher-Mitchell Counties Medical Society recently elected 1947 officers as follows: J. W. Young, Roscoe, president; C. A. Rosebrough, Sweetwater, vice-president; S. F. Supowit, Sweetwater, secretary-treasurer; R. O. Peters, Sweetwater, delegate; T. D. Young, Roscoe, alternate; A. H. Fortner, Sweetwater, censor.

Pecos-Jeff Davis-Presidio-Brewster Counties Society

November 24, 1946

(Reported by John W. Pate, Secretary Pro Tem)

Twenty members, their wives, and guests of the Pecos-Jeff Davis-Presidio-Brewster Counties Medical Society were served a Mexican dinner November 24 at the Lockhart Clinic, Alpine, with the compliments of the clinic. W. E. Lockhart, Alpine, presided, and John W. Pate, Sanderson, served as secretary pro tem in the absence of the secretary.

Officers elected for 1947 included the following: John W. Pate, Sanderson, president; C. E. Eaton, Fort Davis, vice-president; W. E. Lockhart, Alpine, secretary.

Upon motion by J. F. Gipson, Fort Stockton, seconded by Drayton Jeter, Alpine, it was agreed to meet the first Sunday of every month. Dr. Jeter moved, seconded by Dr. Lockhart, that no meeting be held in December. The motion carried.

Malone V. Hill, Alpine, who was scheduled to present a paper on hysterectomy, was unavoidably absent. A round table discussion of the increased prevalence of food infection at this season was held. L. A. Lavanture, Marfa, reported a case of a Siamese teratoma delivered recently. General discussion followed.

Charles E. Oswalt was unanimously accepted for membership upon transfer from Tarrant County Medical Society.

Members were reminded that dues are payable before January 1.

Smith County Society

(Reported by William M. Bailey, Secretary)

Resolutions favoring passage of proposed basic science and medical practice act bills were adopted unanimously by Smith County Medical Society recently. At the same meeting officers for the coming year were elected. The officers, all of Tyler, follow: M. H. Moore, president; Jesse Goldfeder, vice-president; William M. Bailey, secretary-treasurer (reelected); T. M. Jarmon, delegate (reelected); E. H. Caldwell, alternate; Mildred Stanley, censor.

Stephens-Shackelford-Throckmorton Counties Society

December 12, 1946

Heart Pain—M. L. Stubblefield, Baird.
Psychomatic Aspects of Rheumatic Fever—W. B. Adamson, Abilene.
The Rh Factor and Its Relation to Obstetrics—Guy L. Patillo, Abilene.
Report on Matters of Interest Pertaining to State Medical Association—R. G. Baker, Fort Worth, Councilor of Thirteenth District.

Stephens-Shackelford-Throckmorton Counties Medical Society met December 12 for dinner in the Burch Hotel Coffee Shop, Breckenridge, followed by the scientific program outlined above.

Tarrant County Society

December 3, 1946

(Reported by W. P. Higgins, Jr., Secretary)

Tarrant County Medical Society met in the Medical Arts Auditorium, Fort Worth, on December 3, with forty-six members present and R. G. Baker, Fort Worth, past president, presiding.

Reports were given by fifteen officers and committees, after which new officers were elected. X. R. Hyde, was named president-elect; J. F. McVeigh, vice-president; W. P. Higgins, Jr., secretary-treasurer (reelected); E. E. Anthony, censor; Frank G. Sanders, trustee; W. B. West, delegate; M. H. Crabb, alternate. All officers are from Fort Worth. May Owen, Fort Worth, who has served the past year as president-elect, will assume the presidency for 1947.

E. L. Howard, Fort Worth, was elected to honorary membership and it was directed that his name be forwarded to the State Medical Association with recommendation that he be elected to honorary membership in that organization.

Tribute was paid Dr. K. H. Beall, Fort Worth, who died November 21.

William A. Knapp, John L. Roan, James M. Walker, and Irvan M. Ward, all of Fort Worth, were elected to membership upon application.

The secretary read a letter from the State Medical Association regarding establishment of an adjudication and a preceptorship committee. After discussion it was decided to defer action until the next meeting.

Tom Green-Eight County Society

October 7, 1946

(Reported by R. M. Finks, Secretary)

Neurologic Aspects of Congenital Defects in the Newborn (lantern slides)—L. M. Helfer, San Antonio.

Thirty-six members and guests of Tom Green-Eight County Medical Society met in the Indian Room, Hotel Cactus, San Angelo, on October 7, with President W. Grady Mitchell, San Angelo, presiding.

L. M. Helfer, San Antonio, in discussing the neurologic aspects of congenital defects in the newborn, spoke of various defects of the surgical type. He expressed a desire for the abolition of the term "birth injury" because it creates in the lay mind a false impression suggestive of poor obstetrics. He advanced two concepts with regard to development of congenital disturbances: (1) a low percentage of spermatozoa in the semen results in defects of the germ plasm; (2) interruption of proper growth processes even in the presence of normal genes. He also touched briefly on diagnosis and treatment of spina bifida, hydrocephalus, subgaleal hematomata, injuries resulting from extreme compression of the head in passing through the birth canal, subdural hematomata, and various other comparatively rare intracranial pathologic conditions.

Victor E. Schulze, San Angelo, chairman of the committee on by-laws, suggested amendments to the constitution and by-laws having to do with election of officers.

Upon motion by R. L. Powers, San Angelo, seconded by J. Marvin Rape, San Angelo, the society voted to recommend that the local health unit discontinue the practice of sending cards advising immunization of children in private practice. A second motion, made by Kermit Brask, San Angelo, and seconded by Victor E. Schulze, San Angelo, recommended that the health unit send cards at six month intervals reading "that the patient consult his own private physician in regard to necessary immunization."

November 4, 1946

(Reported by R. M. Finks, Secretary)

Recent Advances in Antibiotic Therapy—Robert H. Mitchell, Fort Worth.

Tom Green-Eight County Medical Society met at the San Angelo Country Club on November 4 with thirty-four members and visitors present.

Robert H. Mitchell, Fort Worth, discussed the effectiveness of penicillin and streptomycin in treating various diseases. He pointed out that during the period from 1942 to 1946, penicillin had been less effective because of increasing amounts of penicillin K and diminishing amounts of penicillin G, but that now commercial preparations are again containing sufficient quantities of the G factor. He discussed the use of penicillin in treating syphilis, agranulocytosis, diphtheria, scarlet fever, and pneumococcus infections. He indicated that streptomycin is useful in genito-urinary infections because about 60 to 80 per cent of the dosage given intramuscularly is excreted in the urine. He said it is most effective in alkaline mediums and its effectiveness is curtailed by the presence of pus. It is valuable in the treatment of influenzal meningitis, but since it does not osmose into the spinal fluid, it must be given intrathecally as well as muscularly.

Changes in the constitution and by-laws regarding election of officers, presented at the October meeting, were adopted with the amendment that nominations be reported one month prior to election of officers.

Royce William Frust and Ben L. Boynton, San Angelo, and Charles Foster Brown, Sonora, were elected to membership on application.

December 2, 1946

Officers were elected by Tom Green-Eight County Medical Society on December 2 at a banquet in the Cactus Hotel, San Angelo. Those named include R. M. Finks, San Angelo, president; Lewis K. Tester, San Angelo, president-elect; W. J. Swann, Sterling City, vice-president; H. M. Anderson, San Angelo, secretary; J. B. McKnight, Sanatorium, treasurer (reelected); R. E. Windham, San Angelo, delegate; W. Grady Mitchell, San Angelo, alternate; J. Marvin Rape, San Angelo (three years); K. B. Round, San Angelo (two years); and G. N. Nibling, San Angelo (one year), board of censors.

The constitution and by-laws of the society were revised recently to provide for a president-elect; Dr. Tester is the first to hold that position.

Williamson County Society

December 10, 1946

Case of Erythroblastosis Fetalis—B. A. Kirkpatrick, Taylor.
Heart Disease in Children—A. J. McDonald, Taylor.

Wives of members of the Williamson County Medical Society were guests at dinner and a meeting of

the society December 10 at the Taylor Country Club. The scientific program outlined above was presented.

Officers for 1947 were elected as follows: B. A. Kirkpatrick, Taylor, president; Howard Wheeler, Georgetown, vice-president; J. J. Johns, Taylor, secretary-treasurer.

AUXILIARY NOTES

Officers of the Woman's Auxiliary to the State Medical Association of Texas: President, Mrs. George Turner, El Paso; President-Elect, Mrs. Edward C. Ferguson, Beaumont; First Vice-President, Mrs. L. B. Windham, Tyler; Second Vice-President, Mrs. V. M. Longmire, Temple; Third Vice-President, Mrs. R. E. Clark, Memphis; Fourth Vice-President, Mrs. J. E. Hogan, Big Spring; Corresponding Secretary, Mrs. Robert F. Thompson, El Paso; Recording Secretary, Mrs. M. A. Ramsdell, San Antonio; Publicity Secretary, Mrs. J. F. Campbell, Fort Worth; Treasurer, Mrs. Guy Jones, Dallas; Parliamentarian, Mrs. Joe Nichols, Atlanta.

AUXILIARY NEWS

Bell County Auxiliary in October had a tea honoring Mrs. George Turner, El Paso, State president.

Two charter members of the Bell County Auxiliary, Mesdames A. C. Scott, Sr., and L. R. Talley, were guests of honor at the November 8 meeting of the auxiliary at the home of Mrs. V. M. Longmire, Temple. Mrs. Talley, founder of the auxiliary, reviewed the history of the organization. Mrs. Ed McKay and Mrs. Bert DeBord, Jr., were cohostesses and assisted in serving refreshments to fifty-four guests. Mrs. J. W. Pitmann, president, presided at the silver service, which rested on a table centered with yellow chrysanthemums.

The auxiliary sponsored a Yuletime dance December 19 at the Temple High School gymnasium in an effort to raise $100 for the City Federation clubhouse, a project of all federated women's clubs in the city.

Mrs. Raleigh White, widow of the late Dr. White of Scott and White Hospital, Temple, died September 12, 1946, in the Union Station, Chicago, of heart disease.

Ector-Midland-Martin-Howard-Andrews-Glasscock Counties Auxiliary entertained with a banquet at the Odessa Country Club on November 21, at which Mrs. George Turner, El Paso, State president, was honor guest. The medical society was also in attendance at the banquet, for which Dr. and Mrs. E. V. Headlee and Dr. and Mrs. O. A. Fulcher, of Odessa, were hosts. Approximately forty persons were present for the meal, at which autumn table arrangements were used. Mrs. Turner was presented a corsage of white chrysanthemums, and Mrs. J. E. Hogan, Big Spring, local auxiliary president, was presented a chartreuse and yellow corsage of calendula. Dr. J. M. Woodall, Big Spring, president of the medical society, introduced Dr. and Mrs. Turner.

Following the banquet, the physicians adjourned to another room for their program. Mrs. Turner spoke to the auxiliary on the national convention in San Francisco and the activities of the State Auxiliary. She was given a gift of Dresden china by the auxiliary.

Mrs. Headlee distributed yearbooks.

El Paso County Auxiliary was entertained by wives of physicians at William Beaumont General Hospital with a tea November 11 in the Officers' Club at the hospital annex. Mrs. George Reyer was in charge of arrangements, assisted by Mrs. Lucius K. Patterson, Fort Bliss. An Armistice Day theme was carried out in the decorations. Mesdames S. J. Gaddy, Robert F. Thompson, A. D. Long, and A. P. Black, served at the tea table

The El Paso County Auxiliary gave a luncheon in Juarez on November 14 for wives of physicians attending the Southwestern Medical Association meeting in El Paso. Mrs. S. J. Gaddy, president of the El Paso auxiliary, welcomed the visitors. Mrs. Gaddy, Mrs. Joe Carter, and Mrs. F. O. Barrett were in charge of the refreshments. On November 15, a luncheon was given in the Turner Memorial Home with Mesdames Gaddy and Carter in charge.

During the Southwestern Medical Association meeting Mrs. Carter served as chairman of arrangements for entertaining women visitors, with Mrs. Louis Breck as cochairman. Mrs. Gaddy headed the social committee, assisted by Mesdames George Turner, W. L. Brown, A. D. Long, Wickliffe Curtis, William Glasier, J. Leighton Green, Jr., Ralph Homan, Delphin Von Briesen, Earl Rogers, J. J. Gorman, J. D. Peticolas, F. O. Barrett, Leslie M. Smith, David Cameron, and Robert Thompson. Mrs. Barrett was chairman of decorations, and Mesdames John D. Martin and Rogers handled publicity. Mrs. Long was courtesy chairman, assisted by Mesdames Von Briesen, Thompson, Newton F. Walker, Russell Deter, Martin, Paul Rigney, Walter Stevenson, Orville Egbert, F. G. Evans, and Jacob Rogde. Mrs. Thompson was public relations chairman and Mrs. Peticolas transportation chairman. Mesdames C. D. Hunter and Glasier had charge of telephoning.

Grayson County Auxiliary in November heard Dr. Lois Norman, Sherman, explain the needs of the county for additional hospital beds and isolation wards and point out that Texas is forty-fifth among the states in expenditures for health.

The auxiliary voted to place *Hygeia* in thirty-eight schools of the county for three years.

Mrs. Doak Blassingame, Denison, was appointed chairman of the service fund, and Mrs. W. A. Lee, Denison, was named parliamentarian by Mrs. Arthur Gleckler, Sherman, president.

Harris County Auxiliary met November 25 at the Daughters of the Republic of Texas Log House in Hermann Park, Houston. L. D. Morrison, member of the Houston Police Department, spoke on juvenile delinquency.

The auxiliary donated $600 toward a workshop for patients at the Houston Tuberculosis Hospital in which diversional therapy and light occupational activities will be conducted.

Harrison County Auxiliary entertained Mrs. George Turner, El Paso, State president, with a luncheon November 12 at the home of Mrs. John Hill, Marshall. Mrs. S. W. Tenney and Mrs. Frank V. Mondrik were cohostesses. Mrs. Turner spoke on plans for the auxiliary and pointed out that Texas has the second largest auxiliary membership of any state and sixty of the 625 auxiliaries in the nation. Approximately twenty women attended the luncheon, at which Mrs. J. B. Baldwin poured coffee and Mrs. Ray Carter, president of the local auxiliary, assisted in serving.

The luncheon table was laid with an Italian cutwork cloth centered with a lamb and large snowballs made of cake and covered with coconut.

Eight members of the auxiliary entertained Mrs. Turner at dinner in the evening at the Spinning Wheel in Scottsville.

Henderson County Auxiliary honored members of the medical society with a buffet supper in December at the home of Dr. and Mrs. Don Price, Athens. Mrs. A. H. Easterling and Mrs. J. K. Webster, past presidents of the auxiliary, presided at the table, which was laid with a lace cloth centered with an arrangement of holly and bronze chrysanthemums. Seventeen members and guests were present.

Hopkins-Franklin Counties Auxiliary met November 13 at the home of Mrs. W. Ray Hanna, Sulphur Springs, with Mesdames T. H. McConnell and T. P.

Lynch cohostesses. Mrs. L. Faulk, Sulphur Springs, president, reported on a meeting in Dallas at which Mrs. George Turner, El Paso, State president, spoke on the auxiliary and its objectives. Mrs. Faulk relayed an open invitation from Dallas County Auxiliary for the Hopkins-Franklin Auxiliary to attend any of the Dallas meetings.

Three new members, Mesdames H. E. Chandler, Mount Vernon, and A. B. Worsham and W. E. Connor, Sulphur Springs, were welcomed to membership. Mrs. Royal Ramey, Sulphur Springs, was welcomed to associate membership.

Fourteen members responded to roll call with items concerning modern discoveries in medicine.

Jefferson County Auxiliary met November 6 for luncheon at the Avalon Club, Port Arthur, with Mrs. James W. Long and Mrs. D. H. Byrom as hostesses. In a program arranged by Mrs. A. R. Autrey, Port Arthur, Mrs. W. W. Walters reviewed the book "Mamma's Bank Account."—Mrs. G. R. Solis, Publicity Secretary.

Kerr-Kendall-Gillespie-Bandera Counties Auxiliary met November 1 in the home of Mrs. D. R. Knapp, Kerrville, with Mesdames C. B. Mathews, C. F. Culver, and R. K. Simpson as cohostesses. A program dealing with *Hygeia* and legislation was under the direction of Mrs. L. A. Feller, Fredericksburg, and Mrs. H. H. Gallatin, Kerrville.

Under sponsorship of the auxiliary in coöperation with the tuberculosis association, the patch test for tuberculosis has been given to public school children in Kerrville.—Mrs. David McCullough, Publicity Secretary.

Orange County Auxiliary met December 10 with Mrs. T. O. Woolley and Mrs. David Bennett in the Woolley home, Orange. Mrs. Woolley presided at a business session in which it was announced that Mrs. George Turner, El Paso, State president, would be a guest of the Jefferson County Auxiliary in January and that the Orange County Auxiliary had been invited to be present. Refreshments were served to the auxiliary and members of the medical society following the business session. Mrs. Wynne Pearce, Orange, poured coffee.

Taylor-Jones Counties Auxiliary was host to Mrs. George Turner, El Paso, State president, at a buffet supper November 19 at the home of Mrs. Ann O. Smart, Abilene. Mrs. Turner spoke informally on organization policies. Mrs. A. W. Brazda, Ranger, Thirteenth District council woman, was also a guest. Approximately thirty women were present. Mesdames C. L. Prichard, W. J. Mathews, J. M. Daly, Hubert Seale, and E. R. Middleton arranged for the supper.

Washington County Auxiliary held its regular monthly meeting November 25 at the Hotel St. Anthony, Brenham, with Mrs. W. F. Hasskarl, president, presiding. A turkey luncheon preceded the program, for which Mrs. C. E. Southern, Burton, reported on a survey made of state medicine in Russia, Germany, England, and New Zealand. Mrs. M. D. Burnett, Brenham, offered the invocation, and Mrs. W. A. Knolle, Brenham, gave the treasurer's report. It was voted to send $10 to the loan fund to help educate medical students.

DEATHS*

Dr. Enga Mitchell Arnold, Houston, Texas, died of hypertension November 1, 1946, in a local hospital.

Dr. Arnold, son of Dr. J. M. and Alpha C. (Oliphint) Arnold, was born at Trinity on November 10, 1881. He attended the Houston public schools and the University of Texas, Austin, and was graduated from the University of Texas Medical Department, Galveston, in 1907. After serving internships in St. Mary's Hospital, Galveston, and St. Joseph's Hospital, Houston, Dr. Arnold entered private practice in Houston, where he remained the rest of his life. In October, 1926, he moved into the still incompleted Medical Arts Building, thus becoming its first tenant, and occupied the same office until his death.

Since 1909 Dr. Arnold had been a member of the State Medical Association and American Medical Association, through Harris County Medical Society, which he had served as vice-president. He was a member of the South Texas District Medical Society, past president and member of the Houston Eye, Ear, and Throat Society, a member of the Houston Academy of Medicine and of the Texas Ophthalmological and Otolaryngological Society. He had been head of the eye department of Southern Pacific Hospital since 1929; was a member of the Methodist Hospital Staff, of which he was president in 1935; and a member of the Hermann Hospital staff. During World War I Dr. Arnold served overseas as a major in the Army Medical Corps, and since 1924 he had served on the Veterans Administration board. He was a member and on the board of stewards of the Methodist Church, and a member of Knights Templar, the Shrine, and the Masonic Order.

Surviving Dr. Arnold are his wife, the former Mrs. Eugenia Henricks O'Neill, whom he married in New Orleans, April 11, 1940; one brother, W. J. Arnold, Fairbanks; and two sisters, Mrs. Zula Leverton and Mrs. T. O. Bass, both of Houston.

Dr. Khleber Heberden Beall, treasurer of the State Medical Association since 1923, died at his home in Fort Worth, Texas, on November 21, 1946, of coronary thrombosis.

The son of Elias James and Frances (Van Zandt) Beall, Dr. Beall was born January 13, 1878, in Fort Worth. He attended the Fort Worth public schools, the old Fort Worth University, and the University of Texas, Austin, receiving a bachelor of arts and a master of arts degree from the latter institution. His medical degree was obtained in 1905 from Johns Hopkins University School of Medicine, Baltimore, and he served as intern and assistant resident physician at Johns Hopkins Hospital before returning to Fort Worth in 1909. He was in practice in Fort Worth until his death, specializing in internal medicine, in which field he had obtained foremost rank in Texas.

DR. K. H. BEALL

Dr. Beall was a member of the Tarrant County Medical Society, Thirteenth District Medical Society, State Medical Association, and the American Medical Association throughout his professional career.

*An obituary ordinarily will not be published more than four months after date of death. Coöperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

He had been president of Tarrant County Medical Society and had served the State Medical Association in various capacities for many years. He was secretary of the Section on Pathology in 1909, chairman of the Section on Medicine and Diseases of Children in 1912 and 1933, chairman of the Section on State Medicine and Public Hygiene in 1914, vice-president of the Association in 1914-1915, and treasurer from 1923 until his death. He was also a member of the Texas Club of Internists. He was chief of staff of W. I. Cook Memorial Hospital and with his brother, Dr. Frank C. Beall organized the Beall Clinic. He was the first medical director of the Fort Worth Children's Hospital, a post he held for about twenty years. He was vice-president and member of the board and medical director of the State Reserve Life Insurance Company, director of the Fort Worth National Bank, member of the Fort Worth Public School Board, and former president of the Fort Worth Camp Fire Girls. While serving as a major with the Army Medical Corps during World War I, he was medical consultant at Camp Bowie, and during World War II he was a member of the district appeal board for Selective Service. He was a member of the Christian Church, Beta Theta Pi fraternity, Phi Beta Kappa, Alpha Omega Alpha medical fraternity, Masonic Order, Fort Worth Club, Rivercrest Country Club, and International Brotherhood of Magicians.

On April 19, 1911, in Fort Worth, Dr. Beall married Miss Camilla Weir Labatt, who survives. Also surviving are two daughters, Mrs. William Buchanan Thompson and Mrs. E. Greer Hardwicke; three brothers, Dr. Frank C. Beall, Van Zandt Beall, and Jarvis Beall; two sisters, Mrs. E. D. Capps and Mrs. V. B. Stevens; and one granddaughter, Camilla Thompson, all of Fort Worth.

Dr. Leonard Albert Myers, Houston, Texas, died there November 29, 1946.

The son of Samuel N. and Sophia Myers, Dr. Myers was born August 9, 1896, in Cloud County, Kan. He attended high school in Helena, Okla., and the University of Oklahoma at Norman. He obtained his medical degree from the University of Oklahoma School of Medicine, Oklahoma City, in 1922. He served an internship at Memorial Hospital, Houston, in 1922-1923; was consultant at the United States Hospital, Pineville, La., in 1927-1928; was director of radiology and pathology at Baptist Hospital, Alexandria, La., 1923-1928; and was director of radiology and pathology at Memorial Hospital, Houston, from 1930 until his death. He had carried on postgraduate studies at various medical centers during his career.

From 1931 until his death Dr. Myers was a member of the Harris County Medical Society, State Medical Association, and American Medical Association. He was also a member of the Southern Medical Association, Radiological Society of North America, and Texas Radiological Society. In 1918 he was a member of the Army Medical Reserve and from 1935 until 1941 he served with the Naval Medical Reserve Corps.

Dr. Myers is survived by his wife, the former Miss Olive Corbet, whom he married in 1920; two sons, Leo Alan Myers and Samuel N. Myers; and one daughter, Betty Sue Myers, all of Houston.

Dr. C. C. Collom, Mart, Texas, died October 19, 1946, of hypertension and cerebral hemorrhage.

Dr. Collom was born October 23, 1877, at Armour, now Coolidge, Texas. After being graduated from Trinity College, then at Tehuacana, he spent three years at the University of Texas Medical Department, Galveston, and was graduated in medicine from Vanderbilt University, Nashville, Tenn., in 1901. For many years he did postgraduate work at Tulane University, New Orleans, and in Chicago. From 1901 until ill health forced his retirement in July, 1945, Dr. Collom practiced in Mart.

Throughout his professional career Dr. Collom was a member of the State Medical Association, American Medical Association, and McLennan County Medical Society, serving at one time as president of the latter society. He was a member of the Methodist Church and contributed generously to orphans homes and to Boys Town.

Survivors include his wife, the former Miss Alice Garrett, whom Dr. Collom married in 1902; one son, George Collom, Luverne, Ala.; and one granddaughter, Dale Collom, Clayton, Mo.

Dr. Frederick York Durrance, Houston, Texas, died at his home October 29, 1946, of coronary thrombosis.

Dr. Durrance, the son of John R. and Martha (Carlton) Durrance was born April 29, 1893, in Arcadia, Fla. He obtained his preliminary education in local public schools and was graduated with a bachelor of science degree from the University of Florida in 1920. From May, 1917, to November, 1919, Dr. Durrance served in the United States Army Ambulance Corps. He received his medical degree in 1925 from Tulane University, New Orleans. He served an internship at Touro Infirmary, New Orleans, and was a fellow in radiology at Touro Infirmary and Tulane University until November, 1927. He was then roentgenologist at Beaumont General Hospital, Beaumont Medical and Surgical Clinic, and Jefferson County Hospital and Clinic for Tuberculosis until 1931, at which time he moved from Beaumont to Houston to practice radiology. He was associate professor of radiology at Baylor University College of Medicine, and since 1938 he had been head of the radiological department of Hermann Hospital. For a number of years he was also roentgenologist at the Southern Pacific Hospital.

DR. FRED Y. DURRANCE

Throughout his professional life Dr. Durrance was a member of the State Medical Association and American Medical Association, first through Jefferson County Medical Society and then through Harris County Medical Society. He was also a member of the Houston Academy of Medicine, Radiological Society of North America, and American Congress of Radiology. He was a fellow of the American Medical Association and American College of Radiology, and a diplomate of the American Board of Radiology. He was a Methodist and a member of Phi Rho Sigma, Chi Zeta Chi, and Square and Compass fraternities, and the Gray Lodge in Houston.

Dr. Durrance is survived by his wife, the former Miss Sybil Rodick, of New Orleans, whom he married November 7, 1929; a son, Fred Y. Durrance, Jr., Houston; three sisters, Mrs. M. C. Kayton,

Wauchula, Fla.; Mrs. J. Marion Thompson, Avon Park, Fla.; and Mrs. Jimmie Wertheimer, Cleveland, Ohio; and four brothers, Cecil Durrance, Cleveland, Ohio; R. Neil Durrance, Sebring, Fla.; Hutto Durrance, Zolfo Springs, Fla.; and Oscar L. Durrance, Gainesville, Fla.

Dr. Charles Gilliam Cook, Weimar, Texas, died of apoplexy, November 6, 1946.

Dr. Cook was born October 4, 1875, in Fayette County, Texas, the son of Thomas C. and Fannie (Gilliam) Cook. He received his academic education at Texas Agricultural and Mechanical College, Bryan, and his medical education at Tulane University, New Orleans, from which he was graduated in 1897. He served an internship at Bellevue Hospital, New York City, and had practiced in Weimar for more than forty years.

Throughout his professional life Dr. Cook was a member of the State Medical Association and American Medical Association, through Colorado County Medical Society and, after its organization, of Colorado-Fayette Counties Medical Society. He was president of the Colorado society from 1926 through 1931, 1933 through 1935, and in 1939, and was its secretary in 1938. He was a member of the Methodist Church, school trustee, city health officer, and member of the Masonic Order, Knights of Pythias, and Sons of Hermann. During the Spanish-American War he served as a second lieutenant in the Army.

Dr. Cook is survived by his wife, the former Miss Berry Hall, whom he married October 21, 1903, in Weimar.

Dr. Sidney Mainer Lister, Houston, Texas, died in a local hospital November 16, 1946, of cerebral thrombosis.

Dr. Lister was born October 13, 1875, at Colita, Texas, the son of Walter Sidney and Emma Virginia (Mainer) Lister. His medical education was secured at the University of Texas Medical Department, Galveston, and the Barnes Medical College, St. Louis, from which he was graduated in 1898. He practiced for nine years at Richmond, serving as health officer of Fort Bend County while a resident there. He then moved to Houston, where he was in practice until his death.

DR. SIDNEY M. LISTER

For many years Dr. Lister had been a member of Harris County Medical Society, the State Medical Association, and American Medical Association. He was a past president of Harris County Medical Society and chairman of the Section on State Medicine and Public Hygiene of the State Medical Association in 1913. He was also a member of the Southern Medical Association, a life member of the Postgraduate Medical Assembly of South Texas, and a fellow of the American College of Surgeons. He served as an examining physician for Selective Service in World Wars I and II. He and several colleagues conducted a vigorous campaign to establish a city-county hospital, which ultimately became Jefferson Davis Hospital and which he had twice served as head. He had also been chief of staff at Memorial Hospital, which awarded him a medal in 1940 for thirty-two years of service on its staff. He had been a member of the city and state boards of health, and served for ten years on the Texas Prison Board. He was chairman of the prison board for two years and was instrumental in having the "bat," or leather whip, banned as a means of punishment in Texas prisons. Dr. Lister was a steward in the Methodist Church, vice-president and director of the Gibralter Building and Loan Association, a thirty-third degree Mason, past potentate of Arabia Temple Shrine, and a member of the Houston Club and Houston Country Club.

Dr. Lister was preceded in death August 31, 1936, by his wife, the former Miss Lucile Wilson, whom he married June 2, 1903, in Houston. He is survived by two daughters, Mrs. Hugh Potter, Houston, and Mrs. Alvus E. Armstrong, Cleveland, Ohio; three sisters, Mrs. W. A. Gowen, Mrs. Kate Williams, and Mrs. A. C. Carlisle, all of Waco; two brothers, Dr. John R. Lister, Houston, and U. S. Lister, Dallas; and one granddaughter.

Dr. Howard Albert Mahaffey, Hillsboro, Texas, died November 3, 1946, in a Fort Worth hospital.

Dr. Mahaffey was born February 11, 1874, in Franklin County, Texas, the son of Marion McDonald and Martha Carolina (Bolin) Mahaffey. He attended the public schools of Mount Vernon and the University of the South at Sewanee, Tenn. His medical education was obtained at the University of Texas Medical Department, Galveston, and the University of Louisville School of Medicine, Louisville, Ky., from which latter institution he was graduated in 1903. He was assistant in the gynecologic clinic at the University of Louisville during 1902-1903. He attended the Illinois School of Electro-Therapeutics, Chicago, in 1911. Dr. Mahaffey practiced for a short time in Saltillo and in Winfield, was located in Mount Vernon from 1903 until 1910, and then moved to Hillsboro.

DR. HOWARD A. MAHAFFEY

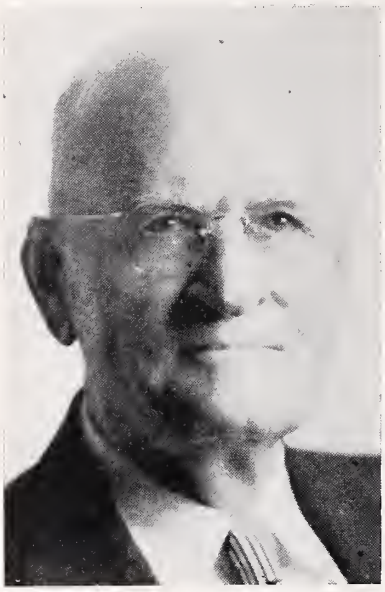
From 1905 until his death Dr. Mahaffey maintained his membership in the State Medical Association and American Medical Association, first through Frankln County Medical Society and then through Hill County Medical Society. He had been president of the Hill County Medical Society, county health officer for many years, local physician for the Missouri, Kansas, and Texas Railroad for many years, and examining physician for Selective Serv-

ice in Hill County during World War II. He was a member of the Baptist Church, Woodmen of the World, and Chamber of Commerce. He was a regular contributor to the Boy Scouts and to Boys Town.

In 1900 Dr. Mahaffey married Miss Leila McGhee, of Mount Vernon, who died in 1910. In 1913 he married Miss Minnie Kate Corley, who died in 1939. Survivors include two daughters, Mrs. Ray O. Shaffer, Fort Worth, and Mrs. Thomas H. Hickey, Hillsboro; one son, Howard A. Mahaffey, Jr., Dallas; four grandchildren; three brothers, W. T. Mahaffey, M. M. Mahaffey, and Charles B. Mahaffey, all of Mount Vernon; and two sisters, Mrs. T. J. H. McLeod, Oglesby, and Mrs. L. T. Youngblood, Bronte.

Dr. **Luke B. Stephens**, Paris, Texas, died in his sleep November 18, 1946, while on a deer hunting trip near Llano.

Son of John A. and Sallie (Ball) Stephens, Dr. Stephens was born February 9, 1876, at Buford, Ark. He was graduated from Baylor University College of Medicine, then in Dallas, in 1905, and began practice in Lamar County as a general practitioner. In 1916 he moved to Ballinger and began specializing in eye, ear, nose, and throat, which he studied in postgraduate courses at the Chicago Eye, Ear, Nose, and Throat Hospital and the New York Eye and Ear Infirmary. After service with the Army, Dr. Stephens moved to Paris, where he remained until his death.



DR. LUKE B. STEPHENS

In 1898 Dr. Stephens volunteered for duty with the Army and was a member of Roosevelt's Rough Riders in combat in Cuba during the Spanish-American War. At the time of World War I he was inducted into service in command of a troop of cavalry in the Texas National Guard, later being transferred to the Army Medical Corps, in which he attained the rank of major. During World War II he was a member of the Texas Defense Guard and served on the local Selective Service board.

Dr. Stephens was throughout his professional career a member of the State Medical Association and American Medical Association, through Runnells County Medical Society at the time of his residence in Ballinger and through Lamar County Medical Society at other times. He was president of the Lamar society in 1938. He was also a member of the Fourteenth District Medical Society and the Texas Oto-Laryngological Society. He was a member and deacon of the First Baptist Church, member of the Paris School Board from 1922 until he resigned in 1946, past commander of the Knights Templar and past president of the Lions Club, and a member of all Masonic bodies in Paris. He was active in the United Spanish War Veterans, being a past commander of the Department of Texas and surgeon general of the national organization at the time of his death.

January 3, 1904, in Paris, Dr. Stephens married Miss Sallie J. Whitten, who survives. Other survivors include two sons, Dr. John A. Stephens and Luke Cary Stephens, both of Paris; one daughter, Mrs. B. T. Bowlin, Jr., Houston; one brother, Rev. H. H. Stephens, Abilene; two sisters, Dr. Corrie A. Copeland, Coolidge, Ariz., and Mrs. Varina Jones, Marlow, Okla.; and seven grandchildren.

Dr. **James Thomas Tadlock**, practicing physician in Dayton, Texas, for forty-two years, died of coronary disease at his home September 30, 1946.

Born May 14, 1872, at Elba, Ala., Dr. Tadlock moved in 1876 to Texas with his parents, James Polk and Rebecca Jane (Baker) Tadlock. He attended the public schools of Montgomery County and attended the Sam Houston Normal Institute at Huntsville before receiving his medical degree from the Kentucky University Medical Department, Louisville, in 1904. After serving an internship at Louisville Hospital, Dr. Tadlock returned to Texas and began practice in Dayton, where he was active until his death.

DR. JAMES THOMAS TADLOCK

Dr. Tadlock was for many years a member of the State Medical Association and American Medical Association, first through Liberty County Medical Society, then through Jefferson County Medical Society, and after its organization through Liberty-Chambers Counties Medical Society. He was the first president of Liberty-Chambers Counties Medical Society. He was one of the founders and former director and vice-president of the Postgraduate Medical Assembly of South Texas and past president of the South Texas District Medical Society. He was a founder and director of the Gonzales Warm Springs Foundation, former city and county health officer, and for twenty-five years a local surgeon for the Southern Pacific Railway. At the time of his death he was president of the staff of Kersting Hospital, a county operated hospital at Liberty. Dr. Tadlock was a member of the Methodist Church and had served ten years as chairman of the board of stewards. He was mayor of Dayton for ten years, preferring not to seek reelection two years ago because of ill health. He was president of the Dayton School Board for fifteen years, founder and director of the Dayton State Bank, past president of the Rotary Club, charter member of the Arabia Temple Mystic Shrine in Houston, and had held practically all offices in the Dayton Masonic lodge. He was also a member of the Chamber of Commerce.

Surviving Dr. Tadlock are his wife, the former Miss Mattie D. Ferguson, whom he married in Willis, Texas, June 3, 1903; one son, Donald H. Tadlock, Dayton; and three sisters and two brothers, all of Willis.

REUBEN B. ANDERSON, JR., A. B., M. D.
(1894-1947)
Assistant Secretary-Editor
State Medical Association of Texas
Fort Worth, Texas

Texas State Journal of Medicine

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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION AND PUBLIC HEALTH IN TEXAS

Dr. Reuben Bennett Anderson, Jr., Fort Worth, for twenty years assistant secretary of the State Medical Association of Texas, and assistant editor of the TEXAS STATE JOURNAL OF MEDICINE, died in his office, at Fort Worth, January 2, 1947, of coronary occlusion.

Dr. Anderson was born December 14, 1894, at Seguin, Texas, the son of Dr. Reuben Bennett Anderson and Mrs. Ella Conway Anderson. He was educated in the public schools of Sherman, Texas, and Austin College, Sherman, from which latter institution he was graduated with the degree of bachelor of arts in 1914. He received his medical education in the Medical Branch of the University of Texas, Galveston, being graduated from that institution with the degree of doctor of medicine in 1918. During his senior year, he served an internship at John Sealy Hospital, Galveston. He later took postgraduate work in eye, ear, nose, and throat at Charity Hospital, New Orleans.

Following his graduation in medicine, during World War I, Dr. Anderson accepted a commission as lieutenant in the Medical Corps of the Navy, serving in that capacity for two and one-half years, first at a station in New Orleans, then with the transport service, and following that at a station in Santo Domingo. Following his discharge from the Navy, he returned to Texas in 1921, locating at San Marcos for the practice of general medicine. He moved from San Marcos to Thorndale, in 1923, entering general practice at that place in partnership with the late Dr. E. L. Laurence. In 1927, he moved to Fort Worth, joining the staff of the State Medical Association of Texas, as assistant secretary-editor, which connection he held at the time of his death.

Dr. Anderson was a member of the State Medical Association of Texas, through the Hayes County Medical Society from 1921 to 1923; the Milam County Medical Society from 1924 to 1927, and the Tarrant County Medical Society from 1927 to 1947. He had been a fellow of the American Medical Association for many years, and an alternate delegate from Texas to the American Medical Association since 1927, during which time he served as delegate at three sessions. He was at one time a member of the Fort Worth Eye, Ear, Nose, and Throat Society.

Dr. Anderson was a member of the St. Andrew's Episcopal Church and served that institution for a number of years as vestryman and as junior warden. He was a Mason and a member of the Sons of Hermann Lodge. He was a past president and a member of the board of directors of the Fort Worth Anglers Club, a former member of the Tarrant County Wildlife Association, and of the Lake Worth-Eagle Mountain Lake advisory board to the Texas Game, Fish, and Oyster Commission. He served on the school board during his years of practice in Thorndale.

Dr. Anderson married Miss Katharine Raynolds of Waco, at Houston, in February, 1918. She preceded him in death, January 31, 1941. He married Mrs. Modena Hackney Landess of Fort Worth, December 27, 1944. Mrs. Anderson, with a daughter by a former

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marriage, Mary Jacquelyn Landess, survive him. He is also survived by a daughter, Mrs. Robert W. Spence, Jr., and her twin daughters, Katharine Ann and Mary Patricia Spence, Austin; a sister, Mrs. F. R. Early, Bangs; a half-sister, Mrs. L. A. Machemehl, Dallas; a half-brother, Dr. Roland B. Anderson, Orange; and his step-mother, Mrs. R. B. Anderson, Sr., Seguin.

During his service with the State Medical Association, Dr. Anderson contributed notably to each and every activity of the Association. His principal and primary service was with the JOURNAL. Upon the reorganization of the Library of the Association, he became Librarian, and the development of the Library was due mainly to his direction. During World War II, he served as vice-chairman of the Procurement and Assignment Service, and during the latter half of that service practically directed its entire activities. For this service he received a letter of commendation signed by the President of the United States. Upon removal of the office of the Public Relations Committee to the central office of the Association at Fort Worth, Dr. Anderson assumed the chairmanship, and later the secretaryship of the committee and, under instructions from the committee, directed its activities.

It would be most difficult, indeed, properly to evaluate the services of Dr. Anderson, or to express the appreciation thereof by his associates in that service, and the medical profession of Texas. His contributions to the welfare of the medical profession of Texas and its dependent lay public, and, indeed, to the medical profession of the entire country, have been many and important. His replacement will be a problem of the first magnitude.

The Annual Session for 1947 is less than three months away. Perhaps May 5, 6, 7, and 8 are already marked on the calendar, but today should also be marked on the calendar. Now is the time to make reservations for hotel accommodations in Dallas, for rooms will be at a premium and cannot be assured at the last minute.

The Hotels Committee, composed of Dr. Jack G. Kerr, chairman, and Drs. Murphy Bounds, Jo C. Alexander, Glenn D. Carlson, Alvin Baldwin, and Andrew Small, has surveyed the situation in Dallas and has furnished the following information regarding space and rates:

DALLAS HOTELS

Hotel	*Rates*
Adolphus	Double, $2.50-$7.00
Baker	Double, $2.50 up
Clifton	Double, $2.75
Jefferson	$1.50 up
Lakewood Hotel	Single, $3.50-$4.00 Double, $5.00-$6.00
Lawn Hotel	Single, $3.50-$4.00 Double, $5.00-$6.00
Lomo Alto Hotel	Single, $3.50-$4.00 Double, $5.00-$6.00
Mayfair	$2.00 up
Melrose	$3.00-$5.00
Southland	$2.00 up
Stoneleigh	Single, from $3.50 Double, from $4.50
White-Plaza	Double, $3.50-$7.50
Whitmore	Single, from $2.00 Double, from $4.00

DALLAS TOURIST COURTS

Court	*Rates*
Grande Lodge	Single, $2.50 Double, $4.00-$5.00
Motor Inn Hotel	Double, $2.50-$3.50 Connecting rooms up to 5 persons, $5.00-$6.00
Tower Hotel Courts	Single, $4.00 Double, $5.00 Twin beds, $6.00
Town House Tourist Courts	Double, $6.00 Twin beds, $7.00

If difficulty in securing reservations is encountered, members of the Hotels Committee, all of whom can be reached at the Medical Arts Building, Dallas, will be glad to assist in securing satisfactory accommodations.

Other committees are at work preparing for the annual session. The Council on Scientific Work met in Fort Worth on January 19 to consider the programs arranged by officers of the scientific sections, and other matters directly concerned with the program as a whole. Most of the section programs were complete or very nearly so, and the speakers and subjects planned for the May meeting promise an interesting and instructive session.

Additional details concerning the program will be announced later. In the meantime, those who wish to attend the annual session in Dallas are urged to make hotel reservations at their earliest opportunity.

The Dallas Southern Clinical Society for the sixteenth time will make available this year to physicians of Texas and the Southwest, a clinical conference designed to give the general practitioner and the specialist authoritative and practical information. This sixteenth annual spring clinical conference will be held March 17-20 in Dallas. Hotel Adolphus will be headquarters for the con-

ference, but some meetings will be held in the Baker Hotel, across the street.

Fifteen of the country's eminent medical teachers will be presented in general assembly addresses designed to appeal to all those who attend. Symposia and afternoon and evening lectures on correlated subjects are planned, and questions on pertinent subjects will be welcomed at the daily round table luncheon conferences. The distinguished guests who will lead the thinking in these programs include the following:

Dr. Elmer Belt, Los Angeles (urology).
Dr. William Boyd, Toronto (pathology),
Dr. Frank D. Dickson, Kansas City (orthopedic surgery).
Dr. F. Bruce Fralick, Ann Arbor (ophthalmology).
Dr. L. H. Garland, San Francisco (radiology).
Dr. George H. Humphreys, New York (surgery).
Dr. J. R. Lindsay, Chicago (otolaryngology).
Dr. Perrin H. Long, Baltimore (preventive medicine).
Dr. H. G. Poncher, Chicago (pediatrics).
Dr. I. S. Ravdin, Philadelphia (surgery).
Dr. Ralph A. Reis, Chicago (obstetrics and gynecology).
Dr. Newton D. Smith, Rochester, Minn. (proctology).
Dr. Willard Owen Thompson, Chicago (medicine).
Dr. John C. Whitehorn, Baltimore (neuropsychiatry).
Dr. Julius L. Wilson, New Orleans (medicine).

A group of competent Dallas physicians will present a series of postgraduate lectures and participate in Wednesday afternoon clinics. A comprehensive schedule of teaching motion pictures is being arranged, and representative commercial concerns will exhibit.

Every physician who is a member of his county medical society is invited to take advantage of the clinical conference. A registration fee of $15 entitles the physician to participate in all phases of the meeting. Because a large attendance is anticipated, officials of the Dallas Southern Clinical Society recommend that those who expect to be present make hotel reservations immediately, directly with the hotels of their choice, and also register with the executive secretary of the society, 433 Medical Arts Building, Dallas 1, Texas.

The spring conferences of the Dallas Southern Clinical Society have proved their value in the past. There is every reason to believe that the 1947 conference will be equally worth while for the physician who feels a need for further information, and for inspiration.

Texas Participation in the American Medical Association Centennial radio broadcasts has been announced for April 26. On that date, at 3 p. m., Central Standard Time, the National Broadcasting Company network will carry a half hour program on Texas medicine. This Saturday afternoon series, under the general title "Doctors—Then and Now," was begun last December, one state or region in the United States being featured each week.

Dr. Anson Jones, an active participant in both politics and the practice of medicine in Texas during its existence as a republic, and the last president of the republic, will be the leading figure in a dramatization originating in Chicago, based upon historical material supplied by Dr. P. I. Nixon, San Antonio, and Dr. Herbert Gambrell, Dallas, executive secretary of the Texas Historical Society. The last few minutes of the broadcast will originate in Dallas, where Dr. Elliott Mendenhall will speak briefly of the present status of medicine in Texas.

Members of the State Medical Association should keep in mind this radio series, which commemorates the one hundredth anniversary of the establishment of the American Medical Association, and particularly the Texas program, April 26. Physicians and many of their friends will want to listen to this broadcast, which will tell the nation's listeners about a very interesting episode in the great history of a great state, and something of the present day medical service in Texas.

Texas Senators and Representatives Listed.—For the convenience of our readers we are publishing elsewhere in this number of the JOURNAL (page 605), a list of Texas Senators and Representatives, with home addresses and by districts. The list should be particularly convenient to those of our readers who wish to address their Senators and Representatives concerning legislative matters now pending, in which the medical profession is interested. During the week, of course, the addresses of all will be "Capitol Station, Austin, Texas." Occasionally, the addresses will be at the home towns of those addressed. That matter cannot be anticipated.

It seems of vital importance to the public health and the medical profession, that our Legislators, both Senators and Representatives, be advised as to the purpose and purport of the several measures which are pending in the Legislature, and it will be a service to them if we individually advise them. There are those in the Legislature who have definitely committed themselves as against any or all of our legislative objectives, while there are those who have expressed themselves as favorable thereto, and in the same degree. They are all entitled

to our suggestions, advice, and explanations. They will not all be convinced, but a serious effort on our part will at least be a discharge of duty.

Of particular import at the present time is the bill providing for a Board of Basic Science Examiners, and a subsequent measure to provide for a new Board of Medical Examiners to cover the unlimited branch of the healing art, or school of medicine. We are not disposed to undertake a discussion of these measures here, but it is important that we remember that the Basic Science Examination is intended as a protection for for what is presumed will be a number of Medical Examining Boards, to cover the several branches of the healing art subsequently to be set up. The assurance of a non-partisan board of scientists that applicants for license to practice one of the healing arts are qualified on the basic sciences leaves these boards free to confine their activities to the art of their branch of practice, with a fair degree of protection to the public to start with. There can certainly be no discrimination, or can there hardly be any partisanship in the action of such a board. This legislation should precede all legislation pertaining to medical licensure.

The State Medical Association is very much interested, also, in revising the present outmoded and obsolete coroner's law. Something should be done about that, and done at once, in the interest of justice and the public welfare. The measure providing additional sanatoriums for the care and treatment of the tuberculous, as advocated by the Texas Tuberculosis Association, is also highly important. A movement has been launched looking to the licensing of hospitals and such institutions, based on standards essential to the protection of the public in all phases of hospital service. Indeed, participation in federal funds appropriated for assistance in extending hospital service throughout the country, under the Hill-Burton Bill, will depend upon the assurance of hospital licensing laws. The State Medical Association is likewise interested in securing appropriation for construction of a psychiatric hospital in Dallas. Establishment of the hospital has already been authorized, but no funds have been set aside for the purpose.

Our Membership for 1946 was exactly 5,041. The membership for the year 1945 was 4,614. The largest membership we have ever had until now, was 4,685, in the year 1944.

On February 1, 1946, the paid-up membership for the new year was 1,352. This number can be broken down to regular members, 1,303; honorary members, 8; intern members, 21; military members, 17; and members emeritus, 3.

On February 1 of this year, there were 2,747 members, which can be broken down as follows: regular members, 2,644; honorary members, 37; intern members, 56; military members, 7; and members emeritus, 3.

Evidently, the change in the fiscal year from the period May to May, to January to January, has hurried up the payment of dues, even though the membership year has not changed from the calendar year, which it has always been. The early payment of dues was urged in order that there might be sufficient funds from the angle of dues to avoid even a temporary deficit in some of the funds of the Association depending upon income from that source. We are grateful to those of our members who have paid early, and to those secretaries who have helped to bring about such a state of affairs.

The annual reports from county societies are due April 1. After that time all former members whose names are not on record in the office of the State Secretary as having paid dues for 1947 are definitely not members any more, and have not been members since the first of the year. Secretaries will receive blanks for their annual reports around March 1, but any secretary who has collected dues from practically all of his members can receive blanks at once by asking the State Secretary for them, and can report without further delay. This is one occasion when it will be satisfactory to all concerned to "jump the gun." It is a grand and glorious feeling when a secretary can unload his membership burden and lie down to pleasant dreams.

Medical Library Service.—Members of the State Medical Association of Texas may take justifiable pride in the library facilities available to them in their own Library. Throughout the years since the establishment of its package service some fifteen years ago, the Trustees have carried forward a policy looking to the continuous development of the Library so that its services to members of the Association might be broadened to the greatest possible extent. An example is the establishment of a collection of medical motion picture films in the Library in 1943, for both lay and professional audiences, which is rapidly becoming one of the best in the United States.

In order to acquire library knowledge and practices that might enhance the services offered by our Library, the Trustees sent one of its librarians to the Library of the

University of Texas School of Medicine, Galveston, for a short period of study during the summer of 1945, through the courtesy of Dr. Chauncey D. Leake, dean and vice-president, and, also, of Miss Elisabeth Runge, its highly accomplished librarian. While there our librarian was not only treated with every possible courtesy but was thoroughly indoctrinated in the system of library practice used.

Through a similar courtesy extended by Col. Leon L. Gardner, then Director, opportunity was given a member of our Library staff to work in and observe the operation of the Army Medical Library, Washington, D. C., from September 23 to October 9, 1946. A concise report of the outstanding facilities of the Army Medical Library, written by Mrs. Estelle Parnell, the member of our Library staff who enjoyed this privilege, appears in the Current Editorial Comment section of this number of the JOURNAL and should be read by every member of the Association. Mrs. Parnell returned not only armed with library knowledge which will be of the greatest value to Texas doctors but inspired by the teaching of Mr. Wyliss Wright, who was at that time the distinguished librarian of the Army Medical Library.

The Army Medical Library is perhaps the greatest medical library in the world. Its facilities are available to any Texas doctor, through a library. It cannot render services directly to individuals. It augments and complements the facilities of all medical libraries of the nation. This magnificent library is faced with the same catastrophic need as our own—a new, fireproof structure to house its priceless contents. Every doctor in Texas should take time out to write his Congressman and urge that prompt and immediate support be given any movement to erect a building in Washington that will make safe for this nation its greatest and most valuable treasure house of medical knowledge, which could never be replaced if lost.

Lastly, the Board of Trustees of the State Medical Association of Texas acknowledges here for its membership deep appreciation of the opportunity offered a member of our Library staff to observe and be trained in the operation of the great Army Medical Library. Through this courtesy accurate and complete information regarding the facilities it has to offer has been brought back and will be widely published to Texas physicians. Again it is urged that the article, "The Army Medical Library," beginning in the next column, be read by every member of the Association.

CURRENT EDITORIAL COMMENT*

The Army Medical Library.—If a Texas medical librarian dismisses a request for information with the apology, "I'm sorry, but we do not have that reference," the patron should not feel that the library is worthless or its staff without merit. The problem is typical throughout the country where medical files are limited. Librarians almost everywhere are forced to shake their heads for the same reason, but an antidote is available in the Army Medical Library at Washington, D. C.

A stranger to the Army Medical Library could not easily believe that this rugged red brick building houses the finest collection of medical literature in the world. Since its founding in 1836, during the administration of Andrew Jackson, with a nest egg of a mere handful of medical books and pamphlets, the Library has accumulated a vast collection of books, pamphlets, journals, portraits, broadsides, curiosa, and the like, coming by purchase and by gift from all parts of the world. In 1879 the Surgeon General reported fifty thousand books on the shelves. Nearly every year since, thousands of books and other forms of medical information have been added to the collection. Also, an incredible grouping of fifteenth, sixteenth, seventeenth, and eighteenth century medical literature has been gathered. In selecting the library's materials, recency of scientific literature is stressed, but not more so than older writings. The aim is to acquire everything published in approved fields of medicine and the allied sciences to the end that there shall be no superior to it in coverage, and it may win the distinction of being the greatest research medical library in the world.

Librarians in the field will be glad to know that much of this material is available to them and to their patrons. The purpose of this enormous grouping of medical knowledge, besides providing a fund of material for the Army medical personnel, is to supplement smaller libraries of the nation with greater medical detail and to provide answers to the rare problems in medicine. There is no line to define the extent of the value of this service. In addition to achieving for the practicing physician and the research worker a broader medical background, the librarian herself can develop the dimensions of her own perspectives and

*This department of the JOURNAL presents editorial comments on current items pertaining to the science, art and practice of medicine, contributed by members of the State Medical Association and scientists closely associated with the medical profession of Texas. Invitation is hereby extended to any member of the State Medical Association of Texas to submit such discussions for this department. The discussions should not be more than 500 words in length.

bring to life dormant powers and potentialities of medical library service.

Too much stress cannot be placed upon the fact that the Army Medical Library does not seek to supplant other medical libraries, but only to supplement them. All civilian requests must be made through a local library, not necessarily medical, and material available through interlibrary loan within the state should not be requested. All requests should be typewritten double space and in duplicate. If postage to cover mailing charges is not sent with the request, the parcel is shipped express collect. Correspondence to the Library should be addressed: The Army Medical Library, 7th and Independence Streets, S. W., Washington 25, D. C.

All members of the medical profession, medical students, and medical librarians are familiar with the *Index-Catalogue*, which is a great scientific bibliography prepared by the Army Medical Library. In August of 1945 the *Current List of Medical Literature* was taken over as an official publication of the Library, and the references indexed, which has made it an invaluable help to the profession in locating references in current periodicals. This has been one of the most outstanding services which the Library has contributed to the public in recent months.

There are certain types of material that are foreign to the average medical library but which World War II has emphasized as necessary adjuncts to total equipment. Photoduplication is one of these auxiliaries. The Army Medical Library has a Photoduplication Section which is regarded primarily as an extension of its loan services. This has been a free service; a nominal charge is now under consideration. For the average practitioner, photostats are more practical in that they are clear and ready to read, but microfilm is available and is satisfactory if a "reader" is at hand.

Single articles from periodicals will be filmed. Each copy shows the name of the author and the name of the publication in which the article appears, thus giving full credit to both author and publisher. All articles requested should be numbered consecutively, and arranged alphabetically under the title of the publication. Each reference requested should include the title of the publication, volume, complete pagination and year, author's full name, and title of the article, thus:

1. American Heart Journal, 10:1-10, 1944, Jones, Arthur A., Sulfanilamide.

The Foreign Language Section will translate verbatim or abstract any article requested *from* or *into* any language except Chinese and Japanese. This service is performed for military and veterans hospitals, the armed services, and federal agencies. One month's time should be allowed for each request, but often material can be prepared the same day it is received. The translation will be sent as a microfilm, as a photostat, or as a typed article. If requested, the illustrations in the article will be photographed and sent with the translation.

Original material is loaned for a period of two weeks from the date of receipt, with the privilege of extension upon request. Transportation charges both ways are borne by the borrower.

Requests for books should show the full name of the author, title of the work, date and place of publication, and name of the publisher.

Journal requests should show the name of the journal, date of issue, volume number, pagination, author and title of the article.

Loans are made on condition that the greatest care will be taken in packing the material for return to prevent damage in transit. Among other precautions, the corners and edges of books should be well protected. Pamphlets and journals should not be rolled but sent flat, and preferably by parcel post. The borrower is expected to pay for repairing damages due to careless packing.

Material dated before 1820, theses dated before 1920, reference works, and any loose leaf material or current journals are not loaned.

The Library's greatest present need is a new building to house its more than one million volumes, because its present home is not fireproof and cannot be further expanded.

In recent years, under the leadership of Col. Leon L. Gardner, as director, and Mr. Wyliss E. Wright, as Librarian, an ambitious program for the Library was begun. Since January 1, a new Commandant, Col. Joseph H. McNinch, M. C., and a new Acting The Librarian, Mr. Scott Adams, have been mapping out and putting into operation new plans, which are eminently worthy of achievement and deserve the wholehearted support of the nation.

Like the Library of the State Medical Association of Texas, the Army Medical Library is not only a place to which one may go to read, relax, and study, but it is also a place from which material is sent to the person who cannot leave his home and his practice.

Estelle Parnell,
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DIAGNOSIS AND TREATMENT OF THE ANEMIAS

WILLIAM C. LEVIN, M. D.
GALVESTON, TEXAS

The anemias are all too frequently considered as primary clinical entities. I believe that the proper concept is that any anemia is secondary to some primary disease or deficiency. In recent years, there have been many new developments, both experimental and clinical, to support this idea. Before Minot and Murphy pointed out the efficacy of liver in pernicious anemia, anemias were classified as primary and secondary types, but this far-reaching discovery soon placed the macrocytic anemias into the secondary group. Since then, more and more of the so-called primary anemias have been found to be the result of some other primary cause.

This development has been aided also by more careful and exact clinical studies. Perhaps the most important of these methods is the technique used to study the bone marrow in living patients. Before the development of this technique, the marrow was rarely examined except in postmortem studies by the pathologist. Now, it is possible to study in detail the organ which produces most of the cellular elements found in the peripheral blood, and correlate any changes found in the two sites. This is helpful in gaining an understanding of the physiological defect, as well as in greatly facilitating the diagnosis of the more obscure anemias.

As stated above, any anemia encountered clinically should be approached with the concept that the anemia is a manifestation of some primary physiological defect. By no means should treatment ever be instituted before an etiological diagnosis is established, and then the therapy should be directed along lines intended to correct the physiological defect.

DIAGNOSTIC METHODS

As in the study of any problem in clinical medicine, it is important first to study an anemic patient with a careful clinical report. Nowhere is a good history more important. A careful dietary investigation is extremely significant in certain types of cases. In infants and children up to 3 years of age, iron deficiency anemia is very common.[2] In such instances, the physician must make certain whether or not the diet contains a sufficient quantity of iron. Again in pregnancy, and especially in multiple pregnancies, the same type of anemia frequently develops.[4] Recently, there have been described instances of macrocytic anemias caused directly by diets deficient in foods containing the extrinsic factor.[7] A history of chronic infection may be the clue to the entire picture. This point has been emphasized by Cartwright and others,[1] who have shown that anemias develop in chronic infections probably because of a disturbance in iron and porphyrin metabolism. It goes without saying that a history of blood loss becomes very important in the study of an anemic patient. Sometimes, however, it is difficult to elicit such a history. This is particularly true in women, most of whom have no idea of what constitutes normal or excessive menstrual flow. Of growing importance in industrial fields is a careful occupational history including any story of contact with chemical or physical agents known to be capable of producing anemias as well as other hematological dyscrasias. Closely akin to this type of history is cognizance on the part of the physician of the frequency with which certain commonly used drugs may produce anemias. The most frequent offenders are the sulfonamides,[3] although other drugs not infrequently may result in the development of anemias. Finally, the history should include a survey of the patient's family, since heredity is definitely established in most of the congenital hemolytic anemias, as well as in certain of the other types.

A thorough physical examination frequently points the way to the diagnosis in the consideration of an anemic patient. Lymphadenopathy and splenomegaly immediately suggest a hemolytic anemia or a leukemia as the etiologic background. Jaundice constantly accompanies hemolytic anemias, while leg ulcers are found only in certain cases. A careful rectal examination may elicit the presence of hemorrhoids or a neoplasm as the source of blood loss. If a neurological examination discloses the presence of combined degeneration of the cord with or without a peripheral neuropathy, a diagnosis of pernicious anemia must be entertained. A hemorrhagic diathesis as the cause of the anemia is intimated by the elicitation of purpuric manifestations during the course of the physical examination. In the female it is the absolute responsibility of the examiner to do a thorough pelvic examination, since the most frequent cause of iron deficiency anemias in the female is pelvic disease which results in chronic loss of blood.

In the great majority of instances a careful clinical survey as outlined above together with ordinary routine laboratory studies is sufficient to arrive at the cause of the anemia. A critical examination of the red count and hemoglobin is frequently sufficient to

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From the Department of Internal Medicine and the Hematology Clinic, University of Texas School of Medicine.

classify the anemia. The leukocyte count and differential may demonstrate the presence of a leukopenia or a specific type of leukocytosis and thus serve as a further guide to the diagnosis. Urinalysis sometimes proves the anemia to be caused by blood loss from the urinary tract or points out the site of an infection. Examination of the blood serologically is very significant, since either secondary or active tertiary syphilis not infrequently produces an anemia in the infected patient. Perhaps one of the most neglected, yet one of the most useful routine laboratory examinations is a careful study of the stool. Many pertinent data may be thus revealed. Hookworm infestation is still a frequent cause of anemia in Texas. The presence of gross or occult blood in the stool will establish the gastro-intestinal tract as the site of blood loss. Absence of free hydrochloric acid in the gastric secretions is of utmost importance in the search for the cause of an anemia, since achlorhydria is a constant accompaniment of Addisonian pernicious anemia and is also frequently found in certain of the iron deficiency anemias.

When the above measures fail to disclose the cause of an anemia, there are certain special laboratory examinations which are indicated. In order to classify the anemia according to laboratory tests, it is necessary to have simultaneous recordings of the erythrocyte count, the hemoglobin content, and a hematocrit examination. With these data it is then possible to calculate the mean corpuscular volume, the mean corpuscular hemoglobin and mean corpuscular hemoglobin concentration according to the following formulae:

1. Mean corpuscular volume $= \dfrac{\text{Vol. packed cells per 1,000 cc. blood}}{\text{Erythrocyte count in millions/cu. mm.}}$

(Normal—80 to 94 cubic microns.)

2. Mean corpuscular hemoglobin $= \dfrac{\text{Hemoglobin in Gm. per 1,000 cc. blood}}{\text{Erythrocyte count in millions/cu. mm.}}$

(Normal—27 to 31 micro-micrograms.)

3. Mean corpuscular hemoglobin concentration $= \dfrac{\text{Vol. packed cells per 100 cc. blood}}{\text{Hemoglobin in Gm. per 100 cc. blood}}$

(Normal—33 to 38 per cent.)

The anemia may then be classified as macrocytic, normocytic, or microcytic and as normochromic or hypochromic. As will be discussed later, this type of classification is a great aid in arriving at the clinical diagnosis.

Estimation of platelet and reticulocyte counts is frequently indicated. If the platelet count is significantly lowered, then two possibilities must be considered. First, if the platelet count is sufficiently decreased, a bleeding tendency will develop and this may account for the anemia. The second important consideration of a subnormal platelet count is that the same process causing the thrombocytopenia has produced the anemia. This situation may be present as a myelophthisic process in which all normal marrow constituents are replaced by leukemic or neoplastic cells, or as a hypoplastic state in which all marrow components are markedly diminished because of the inability of the marrow to function properly. If the reticulocyte count is significantly increased in association with the anemia, the marrow may be considered to be responding adequately to the demands placed upon it. On the other hand, a low reticulocyte count is suggestive of a hypoplastic marrow or of a maturation arrest of the erythroid elements such as occur in the macrocytic anemias. An icterus index and other studies for the detection and classification of jaundice are of great consequence in the diagnosis of hemolytic anemias. In the presence of a hemolytic anemia, the differentiation between the congenital and acquired types can frequently be accomplished if the resistance of the erythrocytes to hypotonic saline solution is studied. In the majority of instances, the congenital type will show increased erythrocyte fragility, while the acquired type of hemolytic jaundice is characterized by a normal erythrocyte fragility test.

In the face of any evidence of a tendency to bleed easily, a complete survey of the clotting mechanism should be carried out. This series of studies would include the prothrombin time, coagulation time, bleeding time, clot retraction, and capillary wall fragility. The defect in coagulation can be recognized in most instances from a careful evaluation of these data. This in turn may disclose the cause of the anemia and point the way to the correction of the defect, if possible.

Perhaps the most helpful of all hematological techniques in diagnosing obscure anemias is an expert study of the marrow. This should be attempted only by those well-trained in such procedures; otherwise, the value of the examination is usually entirely wasted. With such an investigation, the anatomical and physiological defects underlying the anemia can frequently be recognized. For example, myelophthisic lesions may cause severe anemias. These can usually be identified in the marrow as leukemias, myeloma, or metastases from malignancies. The presence of a maturation arrest of the erythroid series can easily be recognized by one experienced in this method. Hypoplastic anemias, too, have very characteristic marrow pictures and are easily recognized.

Any special clinical studies that seem to be indicated should be utilized in anemias of

hidden origin. Some of these to be kept in mind are roentgen and proctoscopic examinations, and biopsy studies of enlarged lymph nodes and masses. There is one final diagnostic procedure that must be mentioned, but only to be emphasized that it should be used only as a last resort. That method is therapeutic trial. In a very occasional case, the type and cause of the anemia cannot be defined, and in such a case it is permissible to utilize one and only one of the specific anti-anemia regimes. Never should such a patient be given both liver and iron, but only one of the specific anti-anemia drugs, so that the result can be more intelligently scrutinized. In such instances, not only the clinical, but also the hematological response must be followed daily in order to evaluate the results and establish the diagnosis.

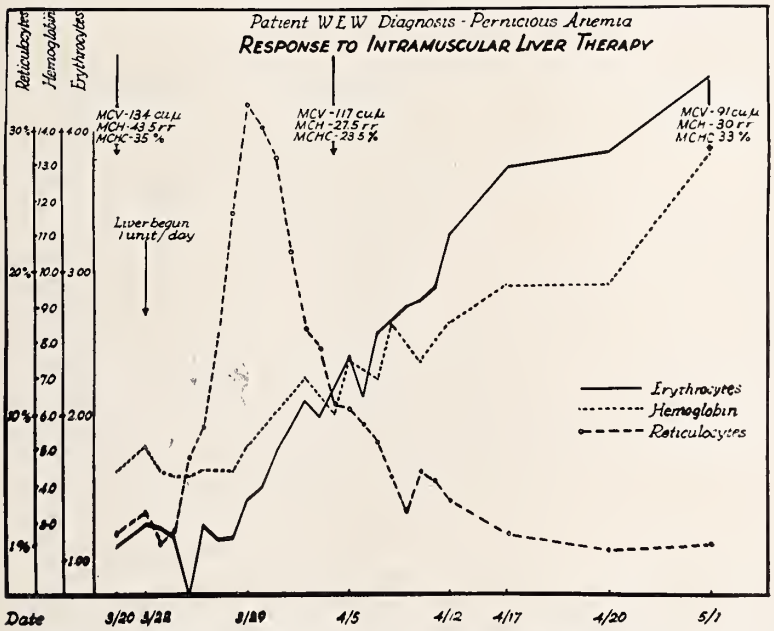

FIG. 1. Proper response of reticulocytes, erythrocytes, hemoglobin, and erythrocyte indices to proper liver therapy.

The primary method of classification of anemias used in our clinic is the laboratory classification which groups the anemias into three types: macrocytic, normocytic, and hypochromic. This grouping is for the sake of convenience, since the clinical types of anemias have been found to arrange themselves into this scheme. The macrocytic anemias are Addisonian pernicious anemia, pernicious anemia of pregnancy, anemia caused by extrinsic factor deficiency in the diet, and anemia associated with chronic liver disease, sprue, gastric carcinoma, and a miscellaneous group of other diseases. The normocytic anemias include those caused by chronic infections, hypoplastic anemias, myelophthisic anemias, hemolytic anemias, anemia from acute loss of blood, and finally a condition characterized by a decreased erythrocyte count and hemoglobin content, which is not a true anemia but is due instead to the hemodilution found in hydremia. The final group is the hypochromic anemias which are comprised of the anemias caused by chronic blood loss and by an iron deficient diet. The latter applies only to infants and adolescents and to females and especially those who have experienced multiple pregnancies or who have had menorrhagia. It can be categorically stated that the presence of a hypochromic anemia in an adult male means that there has been blood loss.

TREATMENT

As stated in the onset, the treatment of anemias should be directed along lines intended to correct the physiological defect. There are, however, certain general measures to be followed which apply to all groups. If the cause can be determined, then that cause should be removed if at all possible. For instance, dietary deficiencies should be corrected and bleeding sources should be removed. In any type of anemia, an adequate and nutritious diet is of the utmost value. Depending upon the severity of the anemia, a proper amount of rest is indicated. A valuable aid in the treatment of anemias is transfusion of whole blood. As will be mentioned later, it is the only method now available for treating certain types of anemias. In more general terms, however, transfusions serve two worth-while purposes. In the first place, transfusions may be life-saving procedures in certain types of severe anemias, most commonly those from acute blood loss. Second, in the event that the grade of an anemia is severe, yet the etiological diagnosis is obscure, a transfusion of whole blood will tide the patient over the critical period, yet it will confuse the diagnostic problem less than any other method available. The final and most important consideration of the treatment of anemias is specific therapy.

It cannot be emphasized too strongly to refrain from instituting treatment until a definite diagnosis has been made. An example of such an error of judgment is exemplified by the case reported here. In this

instance, the patient was subjected to a protracted painful and expensive regime of liver therapy on the basis of a diagnosis of pernicious anemia being made on very poor evidence. An examination of the sternal marrow readily revealed the diagnosis of multiple myeloma.

CASE REPORT

The patient was a 74 year old white woman who entered the John Sealy Hospital with a chief complaint of weakness. The illness began six months previously, the symptoms being weakness, dyspnea, ankle edema, and attacks of nausea and vomiting. She had received a diagnosis at the onset of pernicious anemia. Liver extract was administered in adequate amounts but in spite of this, she continued on a downhill course. Physical examination revealed only marked pallor and severe prostration. The significant laboratory data were as follows: red blood count, 1,830,000; hemoglobin, 5.1 Gms.; mean corpuscular volume, 109 cubic microns; mean corpuscular hemoglobin, 27.8 micro-micrograms; mean corpuscular hemoglobin concentration, 25.5 per cent; platelets, 106,000. Gastric analysis revealed free hydrochloric acid to be present. Bone marrow examination revealed that the normal marrow elements were crowded out by immature plasma cells and the diagnosis of multiple myeloma was thus established.

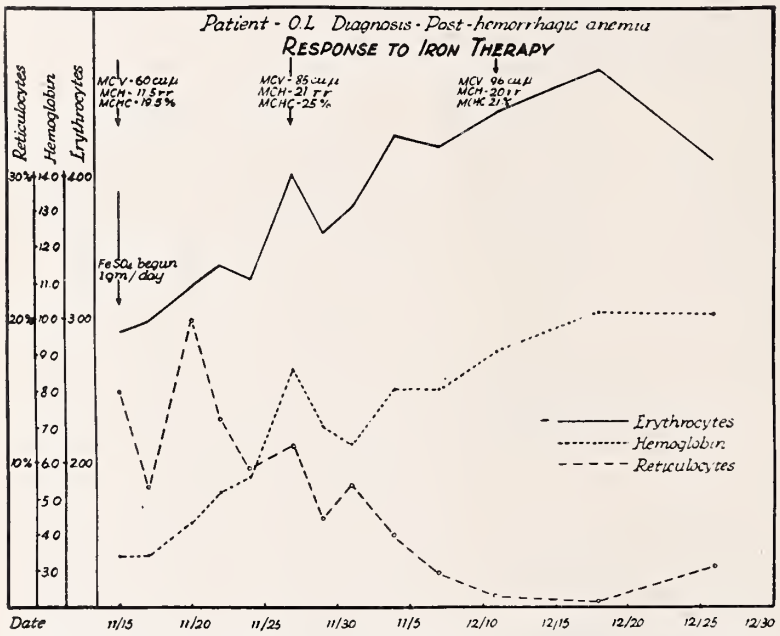

FIG. 2. Hematological response to be expected in a hypochromic anemia treated with iron.

The specific treatment of macrocytic anemias and Addisonian pernicious anemia in particular is now well established. The patient will almost invariably respond beautifully to adequate administration of potent liver extract. A patient with pernicious anemia in relapse is best started off with 10 to 15 units of liver extract intramuscularly daily for about ten days. It may then be decreased to 10 units twice weekly and finally to 10 units every week or even 40 units once a month. Actually, such a patient needs only 1 unit a day to make a satisfactory response, but it is well to replenish the reservoir of erythrocyte maturation factor, which is always depleted during a relapse of pernicious anemia. Figure 1 graphically demonstrates the proper type of response of reticulocytes, erythrocytes, hemoglobin, and erythrocyte indices to proper liver therapy. It will be seen that there was a sudden and short-lived reticulocytosis of marked degree on about the seventh day after specific therapy was instituted. Immediately following this reticulocyte peak, the hemoglobin and red cells began to rise rapidly and had reached normal levels in about six weeks. At the end of this period, the erythrocyte indices had returned to normal.

A word of caution should be injected at this point. Not every patient with pernicious anemia will respond so favorably. There are individual variations, and, in addition, the presence of infection or severe neurological complications frequently demands administration of larger doses of liver extract. An extremely important point is the absolute necessity for permanence of treatment; otherwise relapses may be expected within a few months. There is no indication to use iron in the treatment of macrocytic anemias, unless definite evidence of an associated iron deficiency is present.

A fascinating new material has recently been introduced which doubtless will revolutionize the treatment of macrocytic anemias and perhaps other hematological disorders. This substance is folic acid or the L. casei factor. A recent report has described thoroughly satisfactory responses of Addisonian pernicious anemia, sprue, and pernicious anemia of pregnancy to folic acid, which was administered orally, rectally, and parenterally with equally good results.[8] Folic acid is not yet commercially available, but by the time this paper goes to press, it will almost surely be readily obtainable.

Before specific therapy is instituted in hypochromic anemias, every effort should be exercised toward detecting any source of blood loss, so that the bleeding may be stopped if possible. Iron salts are specific to re-

plenish the body iron. It has been shown that in human beings, ferrous salts are most readily absorbed.[6] We believe, therefore, that ferrous sulfate given in a dosage of 1 Gm. a day, divided into three doses, is the most effective means of restoring the reservoir of iron. Ferrous sulfate should not be administered in enteric coated tablets, since it is necessary for the hydrochloric acid of the stomach to aid in its absorption. There is no need to administer liver extract in any form to a patient with an iron deficiency anemia. Excellent evidence is also available to show that the vitamin B complex aids in no way the treatment of hypochromic anemias with iron.[5] Figure 2 is an example of the type of hematological response to be expected in a hypochromic anemia treated with iron. There is evidence of a moderate reticulocytosis, soon followed by a rise in the erythrocytes and hemoglobin. The response was not completely satisfactory in this patient because during the course of therapy she had a hemorrhage from esophageal varices.

No specific treatment exists at the present for the treatment of normochromic anemias. In this group more than anywhere else it is of greatest importance to be aware of the underlying cause. When the cause is removed, the anemia may be expected to recede. Unfortunately, many anemias of this type are caused by myelophthisic processes or irreversible toxemias. Blood transfusions are of temporary benefit. Liver and iron have no place in the treatment of the normocytic anemias.

In the initiation of treatment of any anemia it is well to follow the subsequent course closely with reticulocyte counts, erythrocyte counts, hemoglobin estimations, and hematocrit studies. These data will then serve three purposes: the diagnosis will be confirmed, adequacy of treatment will be established, and potency of the preparation can be measured.

SUMMARY AND CONCLUSIONS

Anemias are merely symptoms of other primary diseases or deficiencies.

Diagnosis of the anemias depends upon a thorough history, a complete physical examination, and in most instances only routine laboratory studies. In obscure anemias, specialized laboratory work is indicated to aid in the diagnosis.

Treatment of an anemia should be undertaken only after the observer has acquired a thorough understanding of the physiological defect present. Specific therapy should then be instituted. Indiscriminate use of so-called combination therapy is deplored.

Adequacy of therapy may be judged by certain follow-up studies as described in the body of the paper.

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ABSTRACT OF DISCUSSION

Dr. Victor E. Schulze, San Angelo: Erythrocytes, lacking the power of reproduction and regeneration, are subject to change in number and structure only as the result of disease of some other organ. "Anemia," then, is only a symptom which challenges search for the cause. Although this search is facilitated by consideration of the relative size of the cell and its hemoglobin content, the descriptive terms "microcytic" and "macrocytic" or "hypochromic" and "hyperchromic" do not complete the diagnosis. Information other than the quantity of hemoglobin and the number and size of erythrocytes and their respective relations to determine whether the anemia is caused by decreased production, excessive destruction, or loss of blood is of great value in arriving at the etiologic diagnosis. However, since the causes of anemia are numerous and often remote, the study of the patient himself often proves the most fruitful, and the clinical approach to anemia should consequently be in the reverse order in which it is here considered, with the patient first and the blood last, as Dr. Levin has so admirably elucidated.

NAVY NEEDS MEDICAL OFFICERS

The Navy Department has announced that civilian physicians are needed as commissioned officers in the Medical Corps of the Navy or Naval Reserve for active or inactive duty. Long-term programs for training in the recognized specialties as well as in certain Naval medical specialties have been established for medical officers, and are offered as an inducement to the individual physician who wishes to become a specialist without the financial, assignment, and other complications which attend the same effort in civil life. Physicians who are interested may secure further information from the Office of Naval Officer Procurement, Building No. 11, Naval Air Station, Dallas 2, Texas.

"DR. GRAHAM AND FAMILY" BROADCAST

The running story of the life of a general practitioner in a medium sized typical American community is being portrayed in a weekly radio broadcast sponsored by the American Medical Association and the Mutual Broadcasting System. "Dr. Graham and Family" is presented each Monday night at 9:30, Central Standard Time. Begun February 3, the series will continue for twenty-six weeks.

PENICILLIN THERAPY IN CONGENITAL SYPHILIS

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There are 136 reported cases of congenital syphilis treated with penicillin.[1, 3, 5, 7, 10] Of those which have been adequately followed, 38 (28 per cent) have become seronegative, 25 (18 per cent) have shown a significant drop in antibody titer, 7 (5 per cent) have had a serological and/or clinical relapse,[7, 10] and 10 (7 per cent) have died.[3, 7] The deaths were not all attributed to syphilis or Herxheimer reactions. The following is an additional report of 40 syphilitic children who received sodium penicillin. Except where indicated (2 cases of congenital syphilis in older children and 3 cases of central nervous system syphilis) no other specific therapy was used, but all received indicated supportive pediatric care.

ACQUIRED SYPHILIS IN CHILDREN

Three children with acquired syphilis were treated five months, ten days, and six months, respectively, after the onset of symptoms. In all 3 children the clinical evidence of disease disappeared within six days after therapy was started. Except for a transient spike of fever to 102 F. in 2 cases, there was no reaction. In 2 children the blood Wassermann tests became negative five months and seven months after treatment. The third child, who had symptoms of disease antedating his admission by at least six months, showed a small amount of reagin still present six months after treatment. The response of these children to penicillin was similar to that of adults with early acquired syphilis.

CONGENITAL SYPHILIS IN THE NEONATAL PERIOD

Twenty-two infants from 2 weeks to 8 months of age were treated with 500,000 to 2,000,000 units of penicillin. Of these children 21 had a history of symptoms of syphilis, 20 had clinical evidence of syphilis, 20 had roentgen evidence of bone involvement, and 14 gave positive spinal fluid Wassermann reactions. The spinal fluid of 1 child (case 11205, table 2) showed signs of active disease. Skin lesions, athrepsia, bleeding tendencies, bone tenderness, and pseudoparalyses improved markedly within three days after therapy was started. Snuffles, adenopathy, and splenomegaly improved much more slowly. Most of the changes in the long bones cleared within eight months after therapy.

Herxheimer reactions were most pronounced in this group. Two children developed marked urticaria, high fever, mild shock, and severe dyspnea about six hours after treatment was started. Each case responded rapidly to oxygen, adrenalin, and a temporary reduction of dosage. Twelve children had a transient spike in temperature of about 103 F. between nine and twelve hours after penicillin was started. One of these children had a temperature rise to

From the Department of Pediatrics, Southwestern Medical College.
Read before the Section on Pediatrics, State Medical Association of Texas, Galveston, May 8, 1946.

TABLE 1.—*Acquired Syphilis.*

Age Race Case No.	History	Findings	Serology	Total Penicillin U/Dose	Reactions	Follow Up
9 yr.	Mother—Serology neg. Untreated	Chancre on vulva with pos. dark field	W. pos. E. pos.	600,000	None	48 hrs. Chancre, vaginitis and rash gone
	Sister—8 yrs. acquired lues 1 yr. ago. Had rash and condyloma	Inguinal adenopathy G. C. vaginitis	Sp. fl. neg.	40,000 Q. 6 H.		1 mo. W. 32 E. pos. 2 mo. W. neg. E. dbt. 5 mo. W. neg. E. neg. 20 mo. W. neg. E. neg.
Col. FF795	Patient—neg. Wass. 1 yr. ago. 5 mo. ago developed chancre, rash and pos. Wass.					
6 yr.	Mother—Serology neg. Untreated	Inguinal adenopathy Penile chancre with pos. dark field	W. 64 E. 4	1 mil.	Spike after 3rd. shot	24 hr. dark field neg.
	Patient—"Kernels" in groin 9 days.		Sp. fl. neg.	5,000 Q. 3 H.		6 days chancre gone 7 mo. W. neg. E. dbt. Exam. neg.
Col. KK526	1 wk. before admission Wass. pos. Eagle dbt.					
4 yr.	Mother—Serology neg. Untreated	Mental retardation Inguinal adenopathy, marked	W. 32 E. pos.	1 mil.	Spike on 7th. day	4 days penile lesion gone 3 mo. W. 4 E. dbt.
	Patient—Mentally retarded. Known masturbator 6 mo. ago stick removed from penis.	Penile chancre with neg. dark field	Sp. fl. neg.	10,000 Q. 3 H.		4 mo. W. 8 E. 2 5 mo. W. 8 E. 1 6 mo. W. 4 E. dbt. Exam. neg.
Col. II364	5 mo. ago dysuria penile swelling. W. dbt. E. dbt. 4 mo. ago W. pos. E. pos. penile lesion unresponsive to supportive therapy					

GGE General glandular enlargement.
W Eagle Wassermann.
E Eagle flocculation test.
W 128 Wassermann 4 plus in a 1:128 dilution and less than 4 plus in a 1:256 dilution.
W 128+ Wassermann 4 plus in a 1:128 dilution. No further dilution carried out.
W dbt Wassermann less than 4 plus in a 1:1 dilution.
W pos Wassermann 4 plus in a 1:2 dilution, not titrated quantitatively.
f. b. Finger breadths.

TABLE 2.—*Congenital Syphilis—The Neonatal Period.*

Age Race Case No.	Mother's History	Patient's History	Findings	Serology	Total Penicillin U/Dose	Reactions	Follow Up
4 mo. White HH63	Wass. neg. 1 mo. before conception Wass. pos. at birth No symptoms	Cold 3 mo. Frequent epistaxis Weeping rash for 2 wks.	Rhagades Rash Leukoplakia Spleen 2 f. b. Liver 4 f. b. Bones pos.	D. F. neg. W. 128 Sp. fl. pos.	½ mil. 5,000 Q. 3 H.	Spike after 2nd shot	1 mo. W. 4 E. 2 f. b. Spleen 2 f. b. Epitrochlear 3 mo. W. neg. E. 1 Liver 4 f. b. baby small 4 mo. W. 8 E. 16 12 mo. W. 8 E. 16 Spinal pos. bones healing 16 mo. W. 16+ E. 16 Readmitted for more penicillin
2 mo. Col. II24	Chancre 2nd mo. for 3 mo. At 5 mo. Penicillin X. 4 days	Exfoliation 4-8 days of life Cold since 2 wks. old Rash 3 wks. Paralysis 1 wk.	Marked Anemia Paralysis Rash Snuffles Liver neg. Spleen neg. Bones pos. fractures	W. 160 E. 32 Sp. fl. pos.	½ mil. 5,000 Q. 3 H.	Spike after 2nd shot	1 mo. W. 160 E. 2 Bald bones better. Spleen 1 f. b. 2 mo. W. 40 E. 20 3 mo. W. 1 E. 1 7 mo. W. neg. E. dbt. spine neg. bones neg. Exam. neg. 10 mo. W. neg. E. dbt.
8 mo. White II205	Asymptomatic Untreated	Large head 5 mo. Vomiting 3 mo. Fever 5 days Rt. side paralysis 2 days Convulsions 1 day	Hydrocephalus Bulging fontanelle Rt. hemiplegia Stiff neck Spleen 2 f. b. Liver 2 f. b. Bones pos.	W. 100 Sp. fl. very pos. 250 cells 75% lymphs	1 mil. 10,000 Q. 3 H.	Sl. spike after 2nd shot Urticaria	3 mo. W. 4 E. 2 bones neg. Spleen 4 f. b. Liver 3 f. b. sl. G. G. E. Rt. Side weak. Retarded. 6 mo. W. 1 E. dbt. Spinal neg. Spleen 2 f. b. Sl. weakness (rt.) Less retarded. 9 mo. W. 2 E. 2 Head normal, development better.
12 days White HH684	15 years old Rx for 14 mo. prior to delivery	Transferred from nursery Cyanosis from birth Cont. O_2 necessary	Anemia Cyanosis Lungs clear Later developed bronchiolitis Bones pos.	W. 128+ E. 16 Sp. fl. very pos.	1½ mil. 20,000 Q. 3 H.	Spike after 2nd shot Urticaria after 1st and 2nd shot Increased dyspnea Dose dropped to 1,000 & worked up	2 mo. Spinal neg. Exam. neg. 3 mo. W. 1 E. neg. 4 mo. W. 1 E. neg. 6, 7, 11 mo. W. neg. E. neg. 13 mo. W. neg. E. neg. Spinal neg. Exam. neg.
4 mo. White KK783	Asymptomatic Untreated 9 yr. sibling neg.	Cold since birth worse for 3 days Paralysis 1 mo.	Skin thin Nails thick and curved Bloody snuffles Paralysis Spleen 4 f. b. Liver 3 f. b. Bones pos.	W. 128+ E. 32 Sp. fl. pos.	1 mil. 1st adm. 10,000 1 mil. 2nd adm. 10,000 Q. 3 H.	Fever on admission which dropped to normal 2nd adm. none	1 mo. W. 160 E. 20 Bones pos. snuffles Liver 3 f. b. Spleen 2 f. b. 2 mo. W. 80 E. 10 Spinal neg. snuffles, Spleen and liver same. Additional 1,000,000 U. given. 3 mo. W. 16 E. 8 bones better snuffles Spleen 1 f. b. 5 mo. W. 2+ E. dbt. spinal neg. spleen 1 f. b. Development normal. 6 mo. W. neg. E. dbt. Spleen 1 f. b.
3 mo. Col. II298	Asymptomatic Untreated	8 mo. premature Hospitalized from birth Athrepsia Diarrhea	Weakness Anemia G. G. E. Bones pos. with multiple pathological fractures	Pos. Sp. fl. pos.	½ mil. 5,000 Q. 3 H.	Spike after 2nd shot	2 mo. W. neg. bones healing 3 mo. Spinal neg. 6 mo. W. neg. E. neg. bones healing, Spinal neg.
2 mo. White KK765	Rash at 7 mo. when pregnant with patient	Cold since 3 days old Lues diagnosed at 2 wks.	G. G. E. Snuffles Bones pos.	W. 128+ E. 8 Sp. fl. pos.	1 mil. 10,000 Q. 3 H.	Low grade fever before penicillin; became normal after penicillin	1 mo. W. 128 E. 8 Spinal neg. G. G. E. 2 mo. W. 32 E. 4 Bones neg. No G. G. E. 3 mo. W. 16 E. 1 Exam. neg. 4 mo. W. 1 E. dbt. Exam. neg.
5 mo. Col. II969	Rx x 9 mo. 9 yrs. ago Rx during last 4 mo. of preg. 6 neg. Siblings	No symptoms Routine check	Exam. neg. Bones pos.	W. 256+ E. 2 Sp. fl. neg.	½ mil. 10,000 Q. 3 H.	None	3 mo. W. 8 E. 1 Bones neg. Exam. neg.
6 wk. Col. II461	Rx irregularly during last trimester	Cold for 1 mo.	Snuffles Exfoliation of palms	W. 64 E. 8 Sp. fl. neg.	½ mil. 5,000 Q. 3 H.	None	5 mo. W. neg. E. dbt. Bones neg. 8 mo. W. neg. E. neg. Exam. neg.
7 wk. Col. HH939	Asymptomatic 1 premature child Untreated	Cold 10 days Paralyzed 10 days	Snuffles Paralysis Bones pos.	W. 400 E. 32 Sp. fl. pos.	1 mil. 5,000 Q. 3 H.	Low spike after 2nd shot	1 mo. W. 4 E. 2 Bones better Sl. G. G. E. 2 mo. W. neg. E. 1 Bones better 8 mo. W. neg. E. neg. Spinal neg. Bones better 11 mo. W. neg. E. neg. Bones normal Exam. neg.
3 mo. Col. GG993	Irregular Rx previously No Rx with this pregnancy 1 Sibling 14 mo. pos.	Mild continuous epistaxis 1 week Pain on movement 1 wk.	Tender bones Bloody snuffles Spleen 5 f. b. Liver 4 f. b. Anemia Bones pos.	W. 256+ Sp. fl. pos.	½ mil. 5,000 Q. 3 H.	None	1 mo. W. 256+ E. 4 bones same, snuffles Spleen 5 f. b. Liver 4 f. b. 2 mo. W. 16 E. dbt. bones better 14 mo. W. neg. E. neg. Spinal neg. Exam. neg.
3 mo. Col. HH279	Chancre & Rash 4 yrs. ago Took 10 shots at that time	Paralysis 1 wk. with swelling of wrists	G. G. E. Snuffles Paralysis Spleen 4 f. b. Bones pos.	W. 128 Sp. fl. pos	½ mil. 5,000 Q. 3 H.	Spike after 2nd shot	2 mo. W. 32 E. 8 4 mo. W. 8 E. dbt. 6 mo. W. 1 E. neg. Spinal neg. 8 mo. W. dbt. E. neg. exam. neg.
3½ mo. Col. HH282	Asymptomatic Untreated	Cold 2 wks. Rupture since birth	G. G. E. Snuffles Liver 4 f. b. Spleen 4 f. b. Inguinal hernia Bones pos.	W. 128 E. 128 Sp. fl. neg.	½ mil. 5,000 Q. 3 H.	None	1 mo. W. 64 E. 8 Spleen 5 f. b. Liver 4 f. b. G. G. E. 11 mo. W. neg. E. dbt.

(Table 2 continued on next page)

TABLE 2.—*(Continued)*

Age Race Case No.	Mother's History	Patient's History	Findings	Serology	Total Penicillin U/Dose	Reactions	Follow Up
2 mo. Col. II654	Few shots 2 yrs. ago	Rash at 2 wks. lasting 1 wk. Paralysis 2 wks.	Spleen 3 f. b. Dactylitis Pathological fractures	W. 16 E. 1	½ mil. 5,000 Q. 3 H.	Spike after 2nd shot	1 mo. W. 4 E. dbt., G. G. E., exfoliation, Dactylitis 2 mo. W. dbt. E. dbt. bones better, sl. G. G. E. 8 mo. W. dbt. E. dbt. bones well 9 mo. W. neg. E. dbt.
7 mo. Col. GG844	Asymptomatic Untreated	Cold since birth Hospitalization advised at 2 mo.	G. G. E. Sl. hydrocephalus Spleen 1 f. b. Snuffles Bones pos.	W. 128 Sp. fl. neg.	½ mil. 5,000 Q. 3 H.	None	6 mo. W. 4 E. 4 bones healing. Slight retardation.
2 mo. Mex. KK377	Secondary lues 9 yrs. ago Rx 7 mo.—9 mo. 10 yrs. ago had 2 miscarriages	Cold since 2 wks. old Not gaining	Snuffles Anemia Exfoliation Bones neg.	W. 128+ E. 64 Sp. fl. pos.	1 mil. 5,000 Q. 3 H.	Spike after 2nd shot Dose reduced	5 mo. W. neg. E. dbt.
4 mo. White FF791	Rx 2 mo. 1 yr. ago Wass. pos. at delivery	Rash 3 wks. Exfoliation 3 wks. Cough 10 days Fever 10 days Vomiting 3 days	Rash Exfoliation Snuffles Enl. liver Bones pos.	W. 256+	½ mil. 3,000 Q. 3 H.	Fever 4th, 5th, 6th day	
1 mo. Col. HH241	Asymptomatic Untreated	Cold all his life Tender legs 1 week Sores in mouth 2 wks.	Tender bones Snuffles Rhagades Spleen 1 f. b. Liver 2 f. b. G. G. E. Bones pos.	W. pos. Kl. pos. Ka. pos. M. pos. Sp. fl. pos	200,000 U. 5,000 Q. 3 H.	Spike after 2nd shot	1 mo. W. pos. E. pos. Bones pos. 4 mo. W. 2 E. dbt. Bones better 9 mo. W. neg. E. neg.
6 wk. Col. KK740	Asymptomatic Untreated	Umbilicus draining since birth	Snuffles Omphalitis G. G. E. Spleen to umbilicus Large liver Bones pos.	W. 128+ E. 8 Sp. fl. neg.	1 mil. 10,000 Q. 3 H.	None	6 mo. W. neg. E. neg.
6 wk. Col. HH834	Rx 1 mo. 8th mo. of preg.	Swelling of hands and feet for 2 wks. Rash for 1 month	Edema of hands and feet G. G. E. Liver 5 f. b. Exfoliation Rash of face Bones pos.	W. 400 E. 32 Sp. fl. pos.	1 mil. 10,000 Q. 3 H.	Spike after 2nd shot	
4 mo. Col. LL623	Wass. neg. at 7 mo. Chancre when baby was 3½ mo. old.	Rash at 6 wks. for 1 week Pale	Anemia Bones very pos.	W. 128 E. 32	2 mil. 20,000 Q. 3 H.	None	1 mo. W. 32 E. 8 Snuffles
2 mo. Col. LL856	Asymptomatic Untreated	Rupture since birth Cold for 2 days Rash 3 wks.	Rash Ing. hernia Exfoliation Anemia Snuffles Bone tenderness Liver 3 f. b. Spleen 4 f. b. Bones pos.	W. 64 E. 16 Sp. fl. pos.	3 mil. 20,000 Q. 3 H.	Spike to 105 Dose dropped to 2,000 and then increased to 20,000	2 wk. W. 32 E. 8 1 mo. W. 32 E. 4 Bones same, snuffles Spleen 4 f. b. liver 3 f. b.

GGE General glandular enlargement.
W Eagle Wassermann.
E Eagle flocculation test.
W 128 Wassermann 4 plus in a 1:128 dilution and less than 4 plus in a 1:256 dilution.
W 128+ Wassermann 4 plus in a 1:128 dilution. No further dilution carried out.
W dbt Wassermann less than 4 plus in a 1:1 dilution.
W pos Wassermann 4 plus in a 1:2 dilution, not titrated quantitatively.
f. b. Finger breadths.

105.4 F. accompanied by moderate dyspnea and slight liver tenderness. The dosage was immediately reduced but there is no evidence that reduced dosage affects the severity or duration of the reaction. In this case, the temperature returned to normal and the dyspnea disappeared within eight hours; the liver tenderness subsided within twenty-four hours. Two children, who were exhibiting a constant temperature of about 101 F. before penicillin was started, had an abrupt drop to normal after therapy was begun. One child developed a spiking fever of about 103 F. on the fourth, fifth, and sixth days with no discernible cause. The temperature returned to normal without reduction of dosage.

Results of treatment in this group are encouraging. Of those who have been followed, 7 have become seronegative within one to six months after therapy and 8 have shown a marked reduction in the titer of reagin. Two children were readmitted for a second course of penicillin, 1 who failed to show continued clinical improvement two months after therapy, and 1 who had become clinically negative but who had a positive serologic picture, a positive spinal fluid, and pathologic changes in the long bones twelve months after therapy.

CONGENITAL SYPHILIS IN OLDER CHILDREN

Six children with marked clinical signs of syphilis, varying in age from 2 to 13 years, were given from 300,000 to 2,000,000 units of penicillin. The condyloma and Clutton's joints cleared rapidly although 1 child developed Clutton's joints while under treatment. All 3 patients with interstitial keratitis improved slowly. The 1 case of peri-

TABLE 3.—*Congenital Syphilis—The Older Child.*

Age Race Case No.	Family History	Patient's History	Findings	Serology	Total Penicillin U/Dose	Reactions	Follow Up
7 yr. Col. LL145	Father—chancre 8 yrs. ago Mother—"neg." Wass. Untreated Sibling 1½ yrs. Wass. neg.	Exfoliation for 1 wk. after birth Leg paralyzed for 3 mo. beginning at 3 mo. of age Left eye red 1 mo. Photophobia 2 wk. Right eye red 1 wk.	G. G. E. particularly Epitrochlears Moderate interstitial Keratitis no ulcers Joints normal Sed. rate 32 m. m. 1 hr.	W. pos. E. pos. Sp. fl. neg.	2 mil. 20,000 Q. 3 H.	Spike after 2nd shot	2 wk. Less conj. Rt. knee swollen 1 mo. W. 32 E. 4 Eyes better Knee more swollen 1 mil. u. Penicillin—Knee normal in 5 days 4 mo. W. 4 E. 8 Eyes better Knee normal Imp. of ophthalmologist Improvement no greater than with other types of therapy
9 yr. Col. HH818	Unreliable Mother dead Untreated	Retarded since birth Rash at 1 yr. Painless swelling both knees 3 mo. Photophobia 1 mo. Unilateral conjunctivitis 1 mo.	Mental retardation Clutton's joints Left interstitial Keratitis Deafness Hutchinson's teeth	W. pos. E. pos. Sp. fl. neg.	1 mil. 10,000 Q. 3 H.	None	1 mo. W. 32 E. 16 Keratitis same, Knees better 2 mo. W. 32 E. 16 6 mo. W. 8 E. dbt. 8 mo. W. 8 E. 2 Eyes almost well Knees normal Mentality improved
13 yr. Col. KK665	Unreliable Sibling 12 l. & w. 2 siblings died in infancy Mother dead	Unreliable 3 mo. ago intermittent urticaria with fever for 3 wk. 2 mo. ago swelling of one elbow & both knees 1 mo. ago—1 mil. u. Penicillin 3 wk. ago photophobia & conjunctivitis	Mental retardation G. G. E. Clutton's joints Interstitial Keratitis Hutchinson's teeth Sed. rate 117 m. m. —1 hr.	W. 4 E. 16 Sp. fl. neg.		None	Knees & eyes improved during hospitalization
13 yr. White GG693	Preg. 5 mo. Macerated fetus Preg. 3 mo. Miscarriage Preg. patient Mother died	Since birth—abd. pain & distention 1-8 mo. pain on movement Since 8½ mo. several jaundice attacks At 5 yr. temporary unilateral blindness. Athrepsia all her life Dyspnea 4 yrs. Swollen painful rt. knee 1 yr. Pain in lt. knee and wrist 5 da.	Thin, chronically ill Enl. superficial veins of trunk Hutchinson's teeth. Red tongue Spleen 21c.m. Liver 6c.m. Ascites. Edema legs & thighs Clutton's joints Basal rales, Heart normal Sed. rate 116 m. m. 1 hr.	W. pos. E. pos. Sp. fl. pos.	2 mil. 20,000 Q. 3 H.	Irregular fever 101 dropped to normal after 2 shots & remained there	1 mo. W. 128 E. 64 Sp. 5 f. b. Liver 3 f. b. Knees ok 2 mo. W. 256 E. 32 Sp. 5 f. b. Liver 3 f. b. Ankle edema 3 mo. W. 128 E. 32 Spinal neg. Spleen 5 f. b. Liver 3 f. b. 8 mo. W. 256+ E. 1 Cellulitis Penicillin 200,000 U.—No reaction 13 mo. W. 32 E. 16 Spleen 5 f. b. Liver 3 f. b. Ascites edema 15 mo. W. 32 E. 16 Spleen 5 f. b. Liver 3 f. b. Ascites, edema Readmitted for 4 mil. U.
2 yr. Col. HH289	Neg. Mother untreated	Exfoliation at 4 days for 3 days Painful swollen legs for 6 mos. with limping	Rickets Marked G. G. E. Tender non-pitting edema of extremities. Sabre shins Periostitis	W. 128 E. 32 Sp. fl. neg.	½ mil. 5,000 Q. 3 H.	Gradual spike to 105 beginning after 2nd. shot	1 mo. W. pos. E. pos. 14 mo. W. 1 E. 1 Beginning leg tenderness. Slight G. G. E. Bones still positive. Readmitted for more penicillin.
4 yr. Col. FF176	Father—rash shortly before marriage Mother—known luetic. Now rash and genital lesion Untreated	Rectal sore 2 mo. Rash 1 mo.	Generalized rash Condyloma with pos. dark field	W. 128 E. pos. Sp. fl. neg.	300,000 5,000 Q. 3 H.	None	24 hr. dark field neg. 3 mo. W. 4 E. pos. Condyloma gone 5 mo. W. neg. E. pos. 9 mo. W. neg. E. neg. 12 mo. W. dbt. E. dbt. 20 mo. W. neg. E. neg. 24 mo. W. neg. E. neg. Exam. neg.
8 yr. Col. LL187	Mat. gr. father known luetic 2 mat. aunts C. N. S. luetics Mother untreated W. pos. E. dbt. Father untreated W. neg.	Neg. Normal bright child	None	W. 32 E. dbt. Sp. fl. neg.	4 mil. 40,000 Maph. 5 mg. qd. × 12 Bi. .05 Gm. q2d × 6	Irregular Fever 102 From 10th Thru 14th day	1 mo. W. 32 E. 16 Exam. neg.
12 yr. Col. KK957	Same as above	Mental retardation	G. G. E. Mental retardation	W. 64 E. dbt. Sp. fl. neg.	4 mil. 40,000 Maph. 5 mg. qd. × 12 Bi. .05 Gm. q2d × 6	Irregular Fever 102 From 10th Thru 14th day	1 mo. W. 32 E. 8 Exam. neg.

GGE General glandular enlargement.
W Eagle Wassermann.
E Eagle flocculation test.
W 128 Wassermann 4 plus in a 1:128 dilution and less than 4 plus in a 1:256 dilution.
W 128+ Wassermann 4 plus in a 1:128 dilution. No further dilution carried out.
W dbt Wassermann less than 4 plus in a 1:1 dilution.
W pos Wassermann 4 plus in a 1:2 dilution, not titrated quantitatively.
f. b. Finger breadths.

TABLE 4.—*Congenital Syphilis of the Central Nervous System.*

Age Race Case No.	History	Findings	Serology	Penicillin	Reactions	Follow Up
13 yr. Col. KK190	Mother—luetic, untreated Patient—mentally retarded since birth Now in 2nd grade	G. G. E. Marked mental retardation	W. 16 E. 8 Sp. fl. 1cc .5cc .1cc 4+ 4+ 4+	1 mil. 20,000 Q. 3 H.	Spike after 3rd shot	None
7 yr. White KK569	Mat. g. mother luetic, untreated Mother—luetic, untreated Father—Serology neg. untreated Patient—Asymptomatic	Normal bright boy in 2nd grade	W. 32 E. 16 Sp. fl. 1cc .5cc .1cc 4+ 2+ neg.	1 mil. 10,000 Q. 3 H.	None	1 mo. W. 32 E. pos. Sp. fl. neg. 3 mo. W. 32 E. 2 Sp. fl. 1cc .5cc .1cc 1+ neg. neg. 5 mo. W. 16 E. 4 Sp. fl. neg.
11 yr. White HH429	Mother—luetic, untreated Patient— 1½ yrs. progressive mental decline 1 yr. muscle incoordination & personality change 3 wk. muscle weakness urinary retention & incontinance	Marked mental & personality disorders Inability to walk or talk A. R. Pupils Pos. Babinski	W. 356+ E. 32 Sp. fl. 1cc .5 .1 .01 4+4+3+2+ Protein 56 Cells 29 Gold 444333221000	4 mil. 30,000 Q. 3 H.	None	1 mo. W. 256+ E. 32 3 mo. W. 128 E. 32 Sp. fl. 1cc .5cc .1cc .05cc 4+ 4+ 2+ neg. 6 mo. W. pos. E. neg. Sp. fl. 4+ 4+ 2+ neg. 8 mo. W. 32 E. 8 very sl. mental improvement Later institutionalized
8 yr. White FF949	Mother treatment last 2 trimesters Patient— 3 yrs. ago "encephalitis." Since then progressive mental decline & personality changes	Marked mental & personality disorders Incoherent speech Hallucinations Petit mal attacks	W. 128 E. pos. Sp. fl. 1cc .5cc 1cc 4+ 4+ 4+ gold 0011211000 Protein 46	8 mil. 40,000 Q. 3 H.	None	1 mo. W. 128 E. pos. Sp. fl. 1cc .5cc .1cc .05cc .01cc 4+ 4+ 4+ 5 mo. W. 16 E. 8 Sp. fl. 4+ 4+ 4+ 1+ neg. 10 mo. W. 32 E. dbt. Sp. fl. 1+ neg. Institutionalized
10 yr. White FF10	Mother—extensive therapy before but none during pregnancy Patient— 6 yrs. ago Sporadic therapy 5 yrs. ago developed peculiar gait given 10 malaria chills. Gait has become progressively worse.	Thin Mentality fair Pupils fixed & unequal Atrophy of legs Babinski pos.	W. pos. E. pos. Sp. fl. 1cc .5cc .1cc 4+ 4+ 2+	½ mil. 5,000 Q. 3 H. Bismuth Ethyl Camphorate 2 cc. 2 times wk.	None	Appetite & gait improved during therapy 4 mo. W. pos. E. pos. Spinal 1cc .5cc .1cc 4+ 4+ 1+ Readmitted for ½ mil. U. Penicillin
12 yr. White FF724	Mother C. N. S. luetic untreated Patient snuffles in infancy 8 mo. old convulsion with hemiplegia diagnosed lues but untreated For past 3 yrs. sporadic anti luetic therapy For past 2 yrs. mild mental decline	Hutchinson's teeth Spastic hemiplegia Babinski pos.	W. pos. E. pos. Sp. fl. 1cc .5cc .1cc. .05cc: 4+ 4+ 4+ 4+	2 mil. 20,000 Q. 3 H.	Spike after 3rd shot	None
7 yr. White EE549	Mother, Father 2 siblings & pt. Took intermittent therapy for the past 2 years & all became neg. except pt. For past 6 mo. slight mental decline 3 days ago sudden hemiparesis	Hutchinson's teeth Hemiparesis Hallucinations Drowsiness Pupils sluggish to light	W. pos. E. pos. Sp. fl. 55 cells Protein 104 1cc .5cc .1cc 4+ 4+ 4+ 5555543210	Fever 1½ mil. 20,000 Q. 3 H.	Spike after 3rd shot	6 cabinet treatments with slight improvement 7th treatment—severe reaction followed by semi coma and almost death After 1 wk.—penicillin 1½ mil. u. Within 1 wk. mentality much clearer & complete disappearance of hemiparesis 2 wks. unbelievable improvement in mentality. Sp. fl. 1 cc .5 cc. .1 cc 4+ 4+ 4+ protein 46 gold 555432110 4 mo. Sp. fl. 1 cc .5 cc .1 cc 4+ 4+ 4+

GGE General glandular enlargement.
W Eagle Wassermann.
E Eagle flocculation test.
W 128 Wassermann 4 plus in a 1:128 dilution and less than 4 plus in a 1:256 dilution.
W 128+ Wassermann 4 plus in a 1:128 dilution. No further dilution carried out.
W dbt Wassermann less than 4 plus in a 1:1 dilution.
W pos Wassermann 4 plus in a 1:2 dilution, not titrated quantitatively.
f. b. Finger breadths.

ostitis showed only slight improvement in twelve months. Reactions in this group were not severe. One child had a sharp rise in temperature of 105 F. which dropped to normal without change in dosage. One child was running a low grade fever which dropped to normal after penicillin was started. Results of therapy in this group show 1 child apparently cured, 3 markedly improved, 2 slightly improved. Three of these 6 children were readmitted for more penicillin.

Two asymptomatic siblings 8 and 12 years of age were given 4,000,000 units of penicillin in conjunction with mapharsen and bismuth. For four days during the second week of treatment both of these children ran a similar irregular fever which dropped to normal while treatment continued unchanged. Liver function tests, blood studies and nonprotein nitrogen tests before and after treatment, and daily urinalyses during treatment showed no abnormalities. Both

children were well nourished but gained 5 pounds within one month after penicillin was given. Extreme caution should be used with this type of intensive therapy.

CONGENITAL SYPHILIS OF THE CENTRAL NERVOUS SYSTEM

Seven children (6 white) with central nervous system syphilis from 7 to 13 years of age were given 500,000 to 8,000,000 units of penicillin. One of these was asymptomatic, 1 was mentally retarded since birth, and 5 had definite symptoms of central nervous system involvement from six months to five years before admission. Reactions were practically nil. Results of treatment in this group are not very encouraging. None has shown a reversal of the blood Wassermann test. One, the asymptomatic child, developed a negative spinal fluid five months after therapy. Three children have been inadequately followed and 2 have been institutionalized. One child (case EE 549, table 4) is markedly improved.

CONCLUSIONS

1. Penicillin shows promise of being a very effective therapeutic agent in congenital syphilis either alone or in conjunction with other spirocheticides.

2. The optimum total dosage of penicillin and duration of its administration are still undetermined but both will probably be greater than those used in the past.

3. Herxheimer reactions occur frequently during penicillin treatment of congenital syphilis, and are more marked in young children whose infections are severe.

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ABSTRACT OF DISCUSSION

Dr. Arild E. Hansen, Galveston: My compliments to the author first for the fine presentation and second for her ingenuity in undertaking independently a study of the effectiveness of penicillin in the child with syphilis. She has gathered quite an extensive series of cases which compare favorably with the combined series studied at New Orleans, Baltimore, Philadelphia, and Galveston under the auspices of the Committee on Medical Research of the Office of Scientific Research and Development.

Her most encouraging results were observed in the series of 22 infants from 2 weeks to 8 months of age, which agrees with the reports of other investigators in the field. Of course, it is a question yet as to whether or not the bone changes of the early osteochondritis type actually are influenced by the penicillin as there is a distinct trend toward spontaneous disappearance of this manifestation.

May I mention at this time that most of the work in this field at the University of Texas Medical Branch has been carried on by my colleague, Dr. Erle E. Wilkinson; consequently, I am indebted to him for most of my information along this line. We have not been too favorably impressed with the results in our children with Clutton's joint. In one instance the symptoms flared up in the opposite knee upon completion of the course of penicillin. Likewise, the results in interstitial keratitis have been disappointing on the whole. In 2 instances interstitial keratitis developed after penicillin therapy.

The author apparently used somewhat longer doses than those employed in the early work. Interpretation of results has been rendered more difficult, in fact confusing, because it was learned that certain of the material allocated and used in the early work did not have the potency of the early material.

HYPO-LEYDIGISM AND HYPOPITUITARISM

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Hypo-Leydigism and hypopituitarism are not extremely rare and their etiology, differentiation, and proper therapy have not been adequately emphasized. Hypo-Leydigism in this discussion denotes a decrease or absence of the function of the cells of Leydig and is used in place of the term "hypogonadism in the male." The purpose of this presentation is to discuss the etiologic, diagnostic, and therapeutic aspects of hypo-Leydigism and hypopituitarism, and in addition to emphasize the differentiation of the types encountered with illustrative cases.

Hypo-Leydigism may be primary or secondary. It is to be noted from table 1 that different etiologic factors must be considered. If the condition is primary, a local lesion of the testes may be present. If secondary to hypopituitarism, the secretions of the pituitary gland may be diminished because of a local lesion of the pituitary gland or because of a systemic condition. Such systemic conditions as uncontrolled diabetes mellitus, malnutrition, or chronic infections may reduce the secretions of the pituitary and other glands of the body. A diminished activity of the cells of Leydig may occur, therefore, in such systemic conditions.

The subjective manifestations of hypo-Leydigism vary considerably and depend to a great extent upon the etiology, age of onset, and the amount of psychic trauma. In the primary cases which develop before puberty

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the only complaint is usually delayed puberty. In some instances, however, affected youths have stopped their associations with their classmates, and psychosomatic manifestations have appeared or even become prominent. In cases which develop after puberty the psychic trauma is apt to be extreme, and such manifestations may predominate. Loss of libido or impotence usually cause a great deal of alarm and anxiety. The psychosomatic manifestations of the anxiety state usually predominate.

In cases secondary to hypopituitarism the subjective manifestations caused by diminished function of the pituitary gland may predominate. If, on the other hand, the hypo-Leydigism and hypopituitarism are secondary to uncontrolled diabetes mellitus, malnutrition, or a chronic infection, the manifestations of the latter may be superimposed.

The objective manifestations are variable also. There may be none demonstrable. The external genitalia, however, may be underdeveloped or decreasing in size. The secondary sex characteristics may be absent or regressing. The body shape may be juvenile (prepubertal) or normal, and the voice may not have changed. The hair may be distributed according to the juvenile pattern or reverting to that state. The various objective manifestations of the etiologic factors may be present.

The diagnosis of hypo-Leydigism in a well established case is not difficult if puberty has not occurred. The objective manifestations of the prepubertal state establish the diagnosis, provided puberty should have appeared and simple delayed puberty can be excluded. If hypo-Leydigism occurs after puberty and it is not the result of an obvious lesion of the testes, the diagnosis may be difficult. Subjective manifestations may be prominent, but objective manifestations are usually absent or require weeks to months to be demonstrable. The differentiation of simple delayed puberty from hypo-Leydigism in boys from 15 to 18 years of age is extremely difficult. Several patients of that age group have been observed with moderate obesity and in whom puberty had not occurred. Most of these cases had been diagnosed previously as Froelich's syndrome. Puberty developed promptly in most of these boys following a reduction in body weight by diets low in calories. An erroneous diagnosis of hypo-Leydigism is apt to be made in such cases and the onset of puberty attributed falsely to the hormone therapy.

Once the diagnosis of hypo-Leydigism has been established it is necessary to ascertain whether or not it is primary or secondary. The absence of demonstrable lesions in the testes does not exclude the primary type. The presence of other manifestations of pituitary deficiency such as dwarfism or tissue paper skin over the cheek suggest a secondary type. If, on the other hand, no manifestations of pituitary deficiency are present, the problem becomes more difficult.

A therapeutic response may be of diagnostic significance in well established cases. A favorable response to adequate gonadotropic therapy would establish that the hypo-Leydigism was secondary to hypopituitarism. No response, on the other hand, would be in favor of a primary type. A favorable response to testosterone therapy would be of no definite significance. A favorable response would be obtained in either the primary or secondary types. A favorable therapeutic response to testosterone therapy is not of diagnostic value in cases developing after puberty and in which there are no demonstrable objective manifestations.

Estimation of the hormone excretions in the urine may be of tremendous diagnostic significance. As a rule the androgen excretion will be diminished in definite hypo-Leydigism. Technical difficulties are present in these estimations and in some instances the adrenal glands apparently secrete a steroid comparable to the androgens. The gonadotropic hormone is excreted in the urine in greater amounts in cases of primary hypo-Leydigism and is diminished in those secondary to pituitary deficiency. The urinary hormone estimations have been of definite value in the differentiation of the primary from the secondary type in well established cases. In mild or borderline cases, however, the methods are not sufficiently accurate or the hormone excretions are not constant enough to be of diagnostic significance.

TABLE 1.—*Classification of Etiologic Types of Hypo-Leydigism.*

1. Primary
   - A. Traumatic
   - B. Destructive lesion
     - (1) Neoplasm
     - (2) Tuberculosis
   - C. Undescended testes, bilateral
   - D. Idiopathic
2. Secondary to hypopituitarism
   - A. Primary hypopituitarism
     - (1) Traumatic or mechanical
     - (2) Destructive lesion
       - a. Tumors
       - b. Tuberculosis
       - c. Gummas
       - d. Idiopathic
   - B. Secondary hypopituitarism
     - (1) Uncontrolled diabetes mellitus
     - (2) Improper nutrition
     - (3) Chronic infection

The treatment of hypo-Leydigism will depend upon the etiology. In the primary idiopathic type or types with obvious testicular lesions testosterone therapy is indicated. The propionate and the methyl derivatives are

available and either is effective. The propionate must be administered parenterally, whereas the methyl may also be administered orally or sublingually. I have employed methyl testosterone in most of my cases. It has been administered orally, sublingually, parenterally in oil, and as pellet implantations. Any one of these routes of administration is satisfactory if adequate doses are prescribed. Orally or sublingually approximately 30 to 100 mg. will be required daily. In oil 25 mg. from two to three times weekly will be required, and in pellets from 400 to 500 mg. should be implanted with the expectation that they will be effective for from four to five months.

After the hormone deficiency has been corrected and the abnormal physiology eradicated, the patient will continue to require a maintenance dose of hormone. In such cases I have administered 10 mg. of methyl testosterone orally two to three times weekly, and this dose is apparently adequate.

In cases of hypo-Leydigism secondary to pituitary deficiency preparations containing gonadotropic hormone should be employed. Several such preparations are available. The optimum dosage has not been established. If pituitary dwarfism is present, growth extract may be employed. I have treated all of my patients with dwarfism with the growth extract alone and they have all grown and developed sexually and in stature. The preparation has been administered intramuscularly in doses of 2 to 3 cc. two to three times weekly. After the gonadial deficiency has been corrected a maintenance dose of replacement hormone is indicated. In such cases I have administered 1 cc. of the growth extract or the gonadotropic hormone one time weekly and this dose appears to have been adequate in all cases.

In instances of uncontrolled diabetes mellitus, the diabetes should be brought under control and a sufficient time permitted to elapse before any hormone therapy is instituted. In a vast majority of such cases hormone therapy will be unnecessary. Likewise malnutrition or chronic infection should be eliminated and sufficient time permitted to elapse for improvement before hormone therapy is instituted.

The treatment of impotence will depend upon the etiology. Hormone therapy has not been indicated in my experience and a vast majority of such cases have been the result of psychic difficulties. The correction of those difficulties has been necessary, therefore, in such cases.

The male climacteric has been rare in my experience and the few cases which I have treated have responded to 10 mg. of methyl testosterone orally each day. After the manifestations had subsided a maintenance dose of 10 mg. two to three times weekly was adequate.

CASE REPORTS

CASE 1.—A white man, aged 23 years, entered the hospital complaining of inadequate development of the external genitalia and secondary sex characteristics. He was shy and had limited his social activities to the bare minimum. The body was of the juvenile or prepubertal shape with hair only in the pubic area and there it was sparse. The penis was 1.5 inches in length and the testes were not in the scrotum. The right one was palpable in the inguinal canal and was approximately 1 cm. in diameter. The left one was not palpable in the canal or scrotum. The hypo-Leydigism in this case was primary and was caused by undescended testes.

CASE 2.—A white man, aged 20 years, entered the hospital complaining of inadequate growth and sexual development of eight years duration. He ceased growing and developing at 12 years of age and one year later a tumor (type unknown) of the pituitary was discovered and was removed. Since that time he had not grown or developed. The body was prepubertal in shape and with prepubertal hair distribution. The penis was 1 inch in length and the testes were approximately .5 cm. in diameter. The hypo-Leydigism in this case was secondary to a destructive lesion of the pituitary gland.

CASE 3.—A white man, aged 25 years, entered the hospital complaining of lack of growth and sexual development of twelve years duration. He developed diabetes at 12.5 years of age and it was never adequately controlled. He ceased growing and developing at the age of 12 years. The hair distribution and shape of the body was that of prepubertal character. The penis was 2 inches in length and the testes were approximately 1 cm. in diameter. The hypo-Leydigism in this case was secondary to hypopituitarism, which in turn was secondary to uncontrolled diabetes mellitus.

CASE 4.—A white boy, aged 17 years, entered the hospital complaining of lack of growth and sexual development. He had been a feeding problem from birth and had never eaten the proper types nor amounts of food. He had never grown in a normal manner and his small size became more apparent as the prepubertal growth of his classmates occurred. His development was approximately that of 11 years. Correction of the psychic difficulties which had interfered with his proper food intake permitted him to grow and develop normally and within two years he had nearly overtaken his classmates in size and development. The hypo-Leydigism in this case was secondary to improper nutrition.

CASE 5.—A white boy, aged 14 years, entered the hospital complaining of lack of sexual development. He had always been obese, but had been of average height. The secondary sexual characteristics had not appeared and the external genitalia had not grown for four years. The hair distribution and body shape were prepubertal. The penis was 1 inch in length and the testes were approximately .5 cm. in diameter. Reduction of body weight with a diet insufficient in calories was followed promptly by the onset of puberty. The delayed puberty in this case was that which may be associated with obesity and is frequently called Froelich's syndrome.

CASE 6.—A white boy, aged 18 years, entered the hospital complaining of lack of growth and sexual development and a chronic diarrhea of five years duration. He was of normal size and development until 13 years of age, at which time he developed a diarrhea which had persisted to admission. Following the development of the diarrhea he ceased to grow and develop. His growth and development was ap-

proximately that of a 13 year old boy. Correction of the diarrhea permitted this boy to grow and develop. The hypo-Leydigism in this case was secondary to a chronic infection and improper nutrition.

SUMMARY

The etiology, diagnosis, and therapy of hypo-Leydigism and hypopituitarism have been discussed.

The etiology may be primary or secondary.

The diagnosis depends upon the objective manifestations, urinary hormone excretion, and therapeutic response if objective response is demonstrable. Simple delayed puberty must be excluded.

When the condition is present, the differentiation of primary and secondary types must be ascertained.

The treatment will depend upon the type present and a maintenance dose of hormone should be continued after the abnormal physiology has been eradicated.

Six cases have been presented to illustrate the types which may be encountered.

ABSTRACT OF DISCUSSION

Dr. Raymond Gregory, Galveston: Dr. Greene is to be commended on having called our attention so effectively to the distinction between primary and secondary hypo-Leydigism. It is essential that this differentiation be kept in mind if one is to apply the proper substitution type of therapy in the primary and the proper stimulating therapy in the secondary type of hypo-Leydigism. The use of potent androgenic hormones now available in the secondary type of hypogonadism is not only contraindicated but will, if persisted in, cause damage to the testicle which should be stimulated by the use of gonadotropins.

Proper evaluation of hormonal agents both for therapeutic and diagnostic purposes has been interfered with in the past by lack of potency, particularly of gonadotropic substances. This is still unfortunately the case in regard to the gonadotropins directly derived from the anterior pituitary gland. Further interference has undoubtedly resulted from failure to make sufficiently early diagnoses, particularly in the secondary type of hypo-Leydigism. It is reasonable to believe that the end organ, such as the testicle, may remain unstimulated by the anterior pituitary gonadotropins so long that it will not respond to the presence of these substances. This is well exemplified by cretinism which can be completely corrected by the use of proper endocrine therapy if diagnosed early enough. If too long an interval has elapsed, however, thyroid medication cures but few, if any, of the manifestations of cretinism.

A word of caution is indicated regarding the so-called male climacteric. There can be little doubt that physiological regressions do occur with advancing years. The most ardent proponents of the concepts of the male climacteric admit the extreme infrequency with which the symptom complex is seen. This in itself seems sufficient evidence to warrant the belief that when it occurs it is the result of some disease process rather than a natural physiological change resulting from aging.

The symptoms of the male climacteric are so similar, if not identical, with the symptoms of the various anxiety types of psychoneurosis that it is essential that a proper survey of the patient for psychogenic causes of the symptoms be done in every instance before subjecting him to the potent androgenic substances which are now available. The increase in libido which may result from these substances may be harmful to middle-aged and older men, particularly those with impaired cardiovascular systems.

The metabolic effects of the androgenic hormones will probably be found to have a much greater usefulness in the future than those relating to the purely sexual functions of these hormones.

Dr. Arthur Grollman, Dallas: Hormonal deficiency of the testis is caused by a failure of the interstitial or Leydig cells and may be the result of a great variety of causes.* I doubt very much if all instances in which this failure occurs as a result of malnutrition, chronic infection, diabetes, and so forth can be attributed to pituitary insufficiency although the latter, if primary, will of course induce a failure of this function. However, any debilitating condition regardless of its origin may secondarily induce failure of reproductive function including hypo-activity of the interstitial tissue. Pituitary insufficiency also gives rise to failure of spermatogenesis and paradoxically the administration of testosterone at least in the hypophysectomized animal will prevent this tubular dysfunction. Although testosterone and its derivatives offer the best substitution therapy for failure of the interstitial cells, the results of therapy still leave much to be desired. Large doses are necessary to obtain the desired effects. Although hormone analyses of the urine are of theoretical and experimental importance, I question their practical value clinically, particularly as determined by the excretion of ketosteroid bodies, the greater part of which originate in the adrenal cortex and are not necessarily androgenic in function. Except in the treatment of cryptorchidism, the use of either pituitary or gonadotropic extracts has been very disappointing clinically both in the treatment of reproductive failure as well as in dwarfism.

Dr. Greene, closing: I wish to thank the participants for their excellent cooperation and discussion of this paper. In the human being who has hypopituitarism and hypo-Leydigism, the administration of testosterone does not correct the hypopituitarism. Dr. Grollman is correct in emphasizing that ketosteroid bodies may not be a very good index of the androgen excretion. The treatment of dwarfism by the growth extract, contrary to the experience of a good many other investigators, has been gratifying to me, and we have obtained much better results than we ever anticipated. One of the big difficulties in the treatment of dwarfs has been the expected result by the investigator. Certainly a person who has dwarfism could never be expected to catch up with other persons of the same age group if he has lost many years of time. For an illustration, it would be difficult for a 26 year old dwarf to grow to be 6 feet tall if he was only 3 feet before treatment. I would like to emphasize that the male climacteric in my experience has been extremely rare. I think many, many male patients have been treated who did not have a climacteric.

*Grollman, A.: Essentials of Endocrinology, ed. 2, Philadelphia, J. B. Lippincott, 1946.

CONGESTIVE HEART FAILURE THERAPY

Restriction of salt in the diet with a liberal intake of fluid for patients with congestive heart failure, especially those with coronary and hypertensive heart disease, is recommended by three Boston physicians. Drs. Edwin O. Wheeler, William C. Bridges, and Paul D. White, in the January 4 issue of *The Journal of the American Medical Association*, report that of 35 patients with congestive heart diseases of all types who followed the salt restricted diet faithfully 22 were made better and none was made worse.

PERIANAL AND PERIRECTAL INFECTIONS

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The behavior of infection in the perianal and perirectal regions is so unusual and so peculiar to this area that it is difficult for one to understand completely unless he is well acquainted with the anatomy involved.

For many years perianal and perirectal infections were thought to originate with an abscess and terminate in a fistula; however, subsequent study and a better knowledge of the embryology and anatomy of this region have disclosed the fact that the process is much more complex than had been supposed. There are a number of factors which exert a constant influence on these infections, and it is usually the presence of one or more of these factors which precipitates the infectious process. These are as follows:

1. The constant presence of pathogenic organisms in the area is an ever present threat to the surrounding tissues. All that is needed to initiate an infectious process is some disturbance of that intricate mechanism which balances resistance against infection.

2. A debilitating disease such as diabetes or tuberculosis may be the factor which lowers the resistance to infection in the perianal and perirectal region. At one time it was thought that practically all the infections in this area were tuberculous in origin. The two factors which probably contributed most to this belief were, first, the debilitating nature of the disease, and, second, the prevalence of inadequate surgery with its high recurrence rate. It is now recognized that only about 8 per cent of infections in this area are of a tuberculous nature.[3]

3. The presence of constant trauma in the area is frequently a factor which initiates an infectious process. The anorectum is a busy thoroughfare. It seems if there is not something coming out of it, something is being put into it, so that trauma of some kind constantly threatens.

4. The presence of an abundance of areolar tissue in the perianal and perirectal spaces, having a poor blood supply, encourages the spread of infection. This tissue offers only a minimum amount of resistance to infection so that when it does reach the area, suppuration usually follows.

5. It is a recognized fact that the terminal portion of the large bowel is the site of more infections than any other portion of the colon. This fact alone suggests that there must be some anatomic peculiarity of this region which contributes to the frequency of infection. With this in mind, let us review very briefly the development and anatomy of the area.

The blind end of the hind gut in the vicinity of the allantois becomes dilated about the third week of embryonic life to form a pouch known as the entodermal cloaca. Shortly after the third week, the entodermal cloaca descends and, at the same time, that portion of the ectoderm known as the proctodeum becomes invaginated and the depression thus formed is called the anal pit. In this way, the entodermal cloaca and the proctodeum approach each other. Between the sixth and seventh week, the entodermal cloaca is divided into an anterior urogenital and posterior rectal portion by the urogenital septum which later extends towards the surface until finally it becomes the perineal body. During this time, the entodermal cloaca and proctodeum have become fused to form the anal plate or anorectal membrane. At the eighth week, this membrane is absorbed, leaving a free communication between the rectum and anus; this juncture between the cloaca and proctodeum has as its vestige in the adult the anorectal line which is so important to perianal and perirectal infections.

Because of the difficulty of dissection in the anorectal region, and because of the frequent variations from the normal, the anatomy of this region is widely misunderstood. The descriptions in the anatomy texts have become antiquated, many of the illustrations have become stereotyped, and actually they are not based on anatomic facts. The dissections of Milligan and Morgan,[4] and Gorsch[2] have completely changed the concept of anorectal anatomy and their observations have been confirmed by me in the dissection of fresh specimens secured from the autopsy room. It is with this information at hand that an attempt will be made to bring the anatomy of the anorectal region up to date.

The external sphincter muscle (fig. 1) is now described as consisting of three strata of distinct muscular bundles and the trilaminar arrangement of this muscle follows the general laminated arrangement of the urogenital muscles, which is not surprising since both developed from a single cloacal muscle. The three divisions of the muscle are (1) the subcutaneous external sphincter, (2) the superficial external sphincter, and (3) the deep external sphincter. The subcutaneous portion of the external sphincter muscle is situated immediately below the transitional skin (transiderm), and it is usually distinctly palpable throughout its en-

From the Department of Surgery, University of Texas School of Medicine.
Read before the Texas Society of Gastro-Enterologists and Proctologists, Galveston, Texas, May 6, 1946.

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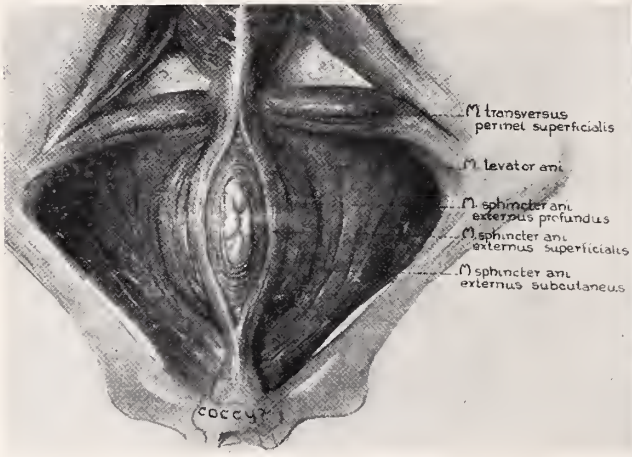
tire extent. This muscle is frequently mistaken for the entire external sphincter muscle, whereas it is but the subcutaneous portion. The bulk of this muscle is usually annular although there are occasionally a few small posterior extensions. The superficial portion of the external sphincter muscle is an elliptical band of fibers which embraces the anal canal in a clamp-like fashion at the level of the internal sphincter. It is the largest, longest, and strongest of the three divisions. It arises from the sides of the coccyx and its diverging halves surround the midportion of the anal canal on each side; then converging, they insert into the central tendinous raphe. None of the fibers is annularly disposed. The deep portion of the external sphincter is situated immediately above the superficial. Its fibers are usually annular and from its anterior portion occasionally are projected insertions as far laterally as the ischial tuberosity.

ment. These fibro-elastic extensions form a fan-like septal network which is observed to penetrate and interweave the actual substance of the muscles, presenting a reticulum-like support for them. They require particular consideration because of their importance to the pathogenesis of the more common anorectal diseases. Those fibro-elastic extensions which are inserted into the anal canal are particularly prominent between the sphincters to form the anal intramuscular septum, sometimes known as the intersphincteric line, or the white line of Hilton. This fascial arrangement fixes and protects the anal canal, preventing its eversion, and acts as tendon sheaths for the divisions of the anal musculature. There is no doubt that these fibro-elastic extensions have a definite directive influence on the extensions of infection to the perianal and perirectal spaces.



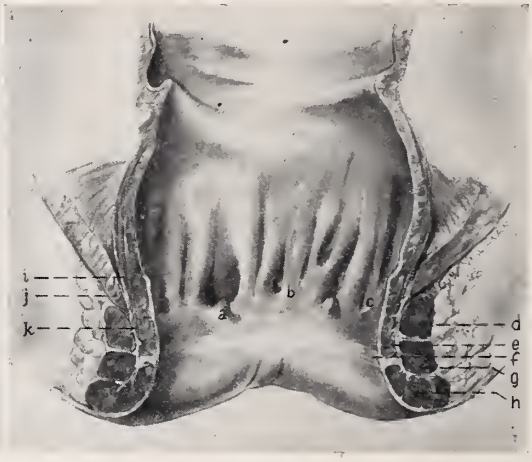


FIG. 1. The anorectal musculature. (After Blaisdell: Surg., Gynec. & Obst. 65:672-677 (Nov.) 1937.)

FIG. 2. The anorectal region: *a*, anal papilla; *b*, rectal column; *c*, anal crypt; *d*, deep external sphincter muscle; *e*, internal sphincter; *f*, anal intermuscular septum; *g*, superficial external sphincter muscle; *h*, subcutaneous external sphincter muscle; *i*, longitudinal muscle; *j*, levator and muscle; *k*, conjoined longitudinal muscle.

The longitudinal muscle coat of the rectum (fig. 2) is formed by an attenuation of the taenia of the sigmoid which spread out to surround the inner circular muscle coat. At the anorectal junction it becomes somewhat more fibro-elastic in character and, fusing with the fascial reflexions of the levator ani muscle, it forms the important conjoined longitudinal muscle. From this muscle are given off fibro-elastic extensions (fig. 3) which surround and penetrate the external sphincter muscle and, to a less degree, the internal, and terminate partially in the lining membrane of the anal canal and partially in the perianal skin as the corrugator cutis ani muscle. In fact, it is the extensions of this conjoined structure which give the external sphincter its essentially trilaminar arrange-

The internal sphincter muscle is the termination of the inner circular muscle coat of the rectum projected into the anal canal. Immediately below its lower margin, it is separated from the upper border of the subcutaneous portion of the external sphincter muscle by the anal intermuscular septum. Overlying the internal sphincter is the important pecten which contains the crypts, glands, connecting lymphatics, capillaries and nerves.

The lining of the anal canal is a transitional membrane, varying from true skin, which, losing its glandular elements, gradually changes to a more or less stratified squamous epithelial surface. This lining terminates somewhat abruptly, but irregularly, at the anorectal line. It is smooth, grayish, poorly vascularized and closely adherent to the underlying tissue. The inter-

muscular septum which lies in the interval between the internal sphincter and the subcutaneous portion of the external sphincter is one of the most important landmarks in the anal canal. Between it and the anorectal line above is a narrow but important upper zone of the anal canal, known as the pecten (mentioned earlier), which varies from 3 to 7 mm. or more in width. The pecten contains the subepithelial areolar tissue which is continuous with the submucosa of the rectum above, and this areolar tissue contains

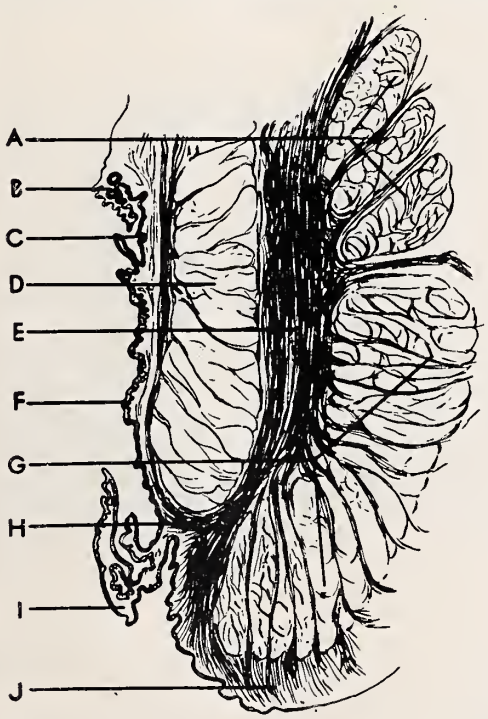


FIG. 3. The conjoined longitudinal muscle. *A*, levator ani muscle; *B*, rectal gland; *C*, anal crypt; *D*, internal sphincter muscle; *E*, conjoined longitudinal muscle; *F*, pecten; *G*, external sphincter muscle; *H*, anal intermuscular septum; *I*, skin tag; *J*, corrigator cutis and muscle. (After Gorsch: Perineopelvic Anatomy from the Proctologist's Viewpoint, New York, Tilghman Co., 1941.)

the anal intramuscular glands and ducts which drain into the anal canal and the recesses of the anal crypts. It is this subepithelial tissue of the pecten with its glands, lymphatics, and capillary network which is of the greatest importance to anorectal infections. Chronic infection of this tissue often results in anal fibrosis or pectenosis and its lowest margin, the anal intermuscular septum, is a frequent location for the primary openings of fistulae. The anorectal line marks the upper margin of the pecten and here are found the crypts, anal valves, rectal columns, and anal papillae. The anal papillae are not characteristic of the anorectal line as they are more often absent than present. The anal crypts are tiny recesses projected between adjacent rectal columns and behind the valves. There is considerable variation in number, depth, and shape of these crypts, the more constant and larger crypts usually being found just to each side of the posterior commissure. The anal intramuscular glands and ducts frequently are connected with the caudal end of the crypts.

It is now generally agreed that practically all perianal and perirectal infections begin at or near the anorectal line. Debris and infection are constantly being forced into the crypts so that when some unusual trauma breaks down the natural barrier, this infection usually obtains a foothold. The infection may begin in an intramuscular gland which empties into the crypts or in the crypt itself, but at any rate, this is the first phase of an infectious process. The picture (fig. 4) which is usually seen at this stage of the process is a cryptitis and an accompanying papillitis—the birth of anorectal infection. Examination reveals the crypts to be marked by a definite hyperemia at their margins and much more prominent than those ordinarily seen. Pressure over one of the involved crypts may obtain a drop of pus or perhaps upon probing the exudate may appear. At any rate, one or more of the crypts are usually much more extensive than those ordinarily seen, sometimes admitting a probe as far out as the anal verge and eliciting a considerable amount of pain on the part of the patient. The papillae usually become involved by the same infection as that involving the crypts, so that a hypertrophy of these structures is frequently seen as a part of the picture. The infection may remain restricted to this area for a considerable period of time, producing chronic symptoms both local and reflex from time to time or no symptoms at all. Occasionally there results a series of small subcryptic abscesses which drain from time to time into the bowel or perhaps progress into one of the more extensive abscesses. These as well as the cryptitis may not produce symptoms sufficiently severe to direct attention to the area, but there is no doubt that they could persistently infect the blood stream to such an extent as to serve as a focus of infection to other systems of the body. All physicians from time to time have been impressed by the disappearance of remote symptoms after eradication of anorectal infection and they will continue to be rewarded if they are alert to these low grade infections. It is probable that only a routine proctologic examination will reveal their presence and permit the necessary treatment.

During the second phase of the process,

infection begins to extend from the crypt in various directions:

1. It may extend beneath the transitional skin of the anal canal, superficial to the anal muscles.
2. It may force its way through the body of the external sphincter.
3. It may burrow through or under the internal sphincter muscle to reach the pelvirectal or retrorectal space.
4. The infection may spread upward in the submucosa to form a submucous abscess in the rectum.

The third stage is characterized by abscess formation in the areola tissue of the perianal and perirectal spaces. These abscesses have been classified by Bacon[1] according to their relation to the levator ani muscle (fig. 5):

I. Infralevator abscesses
   a. Cutaneous (furuncle)
   b. Subcutaneous (usually results from infection extending from the anorectal line)
   c. Ischiorectal (usually results from infection extending from the anorectal line)

II. Superlevator abscesses
   a. Submucous
   b. Pelvirectal
   c. Retrorectal

The abscesses below the levator muscle are usually accompanied by a varying amount of pain, fever, and perhaps chills, and the treatment of choice is early incision and drainage before the process becomes too extensive. The abscesses above the muscle are also characterized by fever and occasional chills, but pain is not a prominent symptom, although occasionally the more extensive abscesses may produce lower abdominal pain and muscle rigidity on the side involved. The submucous type, if bulging into the lumen of the rectum, may be incised inside the bowel, but those in the pelvirectal space should not be incised through the rectal wall, for such an incision will create an internal fistula which will be extremely difficult to treat. Drainage is best secured by an incision just outside of the sphincter fibers, plunging a blunt hemostat through the ischiorectal space, through the levator ani muscle into the abscess cavity. This procedure produces a fistula more amenable to treatment.

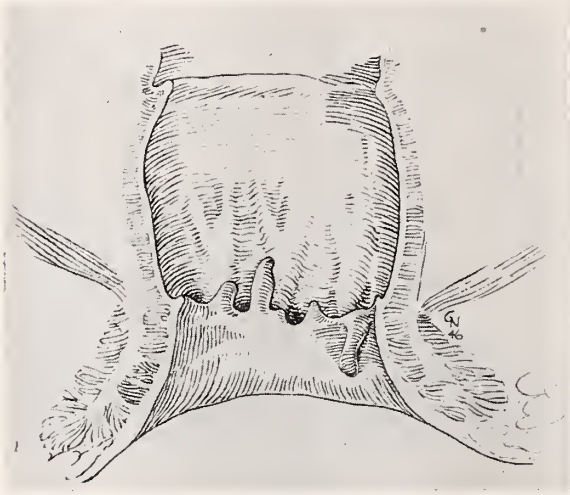


FIG. 4. Cryptitis and papillitis.
FIG. 5. Abscesses of the anorectal region. (After Bacon: Anus, Rectum, Sigmoid Colon: Diagnosis and Treatment, ed. 2, Philadelphia, J. B. Lippincott Co., 1940.)

The retrorectal abscesses are in a space (fig. 6) posterior to the rectum and in front of the sacrum, bounded above by the peritoneal reflection and below by the levator ani muscle. On each side are the lateral ligaments of the rectum. As in the case of the pelvirectal abscesses, these abscesses also should not be drained through the rectal wall, but through an incision just behind and lateral to the posterior commissure of the anus.

There is one point which should be emphasized and that is that these abscesses are not resolved by the sulfonamides or the antibiotics. Correct treatment demands that the pus be evacuated surgically, regardless of its location, as soon as its presence is detected.

In the fourth stage, the abscess either ruptures spontaneously internally or externally, or an operation is performed to evacuate its contents. In either event, the abscess cavity shrinks down and usually a fistulous tract remains. The sequence of events in-

volving this fistulous tract is usually as follows:

1. In 0.5 per cent of the cases, the infectious process apparently subsides permanently.

2. In about 85 per cent of the cases, the infection subsides, and the secondary opening becomes temporarily obliterated. After a certain period of time, the infection becomes reactivated and again drainage occurs through the secondary opening, or perhaps the infection burrows off in a new direction.

3. In about 15 per cent of the cases, the infection remains active and drainage through the tract is almost constant. These fistulas should strongly suggest that the infection is not of the ordinary type. Continued drainage may be the result of (a) tuberculosis, actinomycosis, syphilis, microaerophilic hemolytic streptococcus or lymphopathia venereum infection; (b) a foreign body in the abscess cavity; (c) a massive infection which has been neglected; or (d) osteomyelitis of the coccyx or adjacent bones.

The treatment of choice, of course, is always surgical and includes the complete incision or excision of the fistulous tract from its primary opening to its secondary opening, removing all the diseased tissue, and constructing the wound in such a fashion that it will fill in with healthy granulation tissue from its bottom upward.

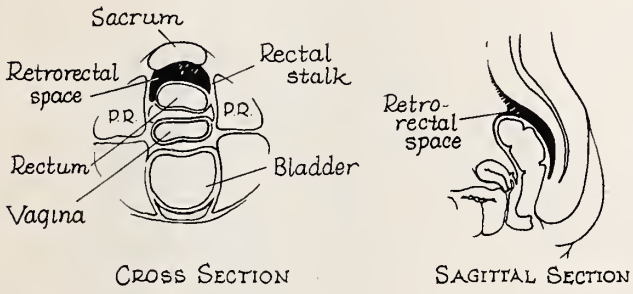


Fig. 6. Schematic drawing of cross and sagittal sections of retrorectal space. showing its anatomic relations.

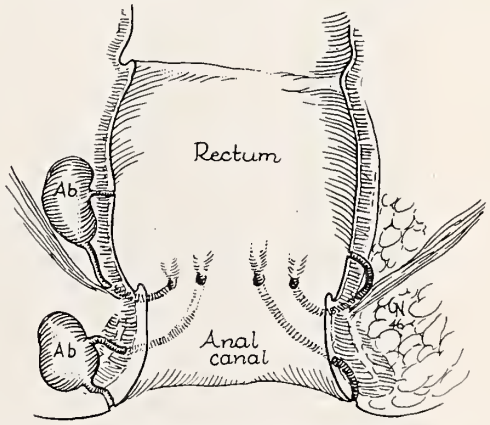


Fig. 7. Anorectal fistulae. The anorectal abscesses are on the left and the resulting fistulae on the right.

SUMMARY

1. Low-grade infections of the anorectal region are frequently unrecognized.

2. Early diagnosis and treatment are essential to an early and complete recovery.

3. It has been necessary to review the development and the anatomy of the anorectal region because a thorough understanding of anorectal infections is predicated on a thorough knowledge of these subjects.

4. A complete proctologic investigation should be included in examining patients, especially in a search for a focus of infection. It should not be reserved for those patients who present symptoms referable to the anorectal region.

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ABSTRACT OF DISCUSSION

Dr. Herbert T. Hayes, Houston: Dr. McGivney's discussion of perianal and perirectal infections has been very ably handled.

He has reviewed for us the etiological factors, which are very important. He called to our mind particularly the fact that tuberculosis, formerly thought to be a very frequent occurrence, is rare in this region.

I think it was very helpful for Dr. McGivney to discuss the anatomy of the anorectal region, especially the anatomy of the muscles, for I think if the surgeon understands the muscle arrangement of the anal canal, he is less likely to get in trouble when operating in this region. It is surprising the number of people who think there is only one small muscle for bowel control and if that is cut there is no control.

Dr. McGivney emphasized another important thing, that is, the amount of infection that is frequently present in the anal canal, even without the patient having a fistula or an abscess. He may have badly infected crypts and hemorrhoids that are a constant foci of infection. All of us have seen patients who could almost be taken to have pernicious anemia. These patients would be worked over completely by the internist and be suspected of having a neoplasm or something else equally as serious, only to find that their anemia was from badly infected bleeding hemorrhoids.

I agree with Dr. McGivney that the rectal abscess should be operated on usually as soon as possible, for most of such abscesses occur in loose tissue and they spread very rapidly. I have encountered 2 during the past year that completely encircled the rectum. In these cases the physician was waiting for the abscesses to come to a head.

I think one of the chief points that Dr. McGivney has tried to put over is the importance of investigating the rectum as a source of infection.

UTEROSALPINGOGRAPHY

REPORT OF A FATALITY

ARTHUR M. FARIS, M. D., and
ALLEN McMURREY, M. D., F. A. C. S.
HOUSTON, TEXAS

The purpose of this paper is to present some of the pathologic entities and developmental anomalies that can readily be demonstrated by uterosalpingography, and to report a fatality which resulted from this procedure. Roentgen visualization of the uterus and tubes, through use of opaque medium injected into these structures, is a valuable aid not only in confirming or disproving suspected lesions but also as a therapeutic measure in certain instances. Its most extensive usefulness is in problems of sterility, pelvic tumors, and congenital malformations. Through the use of stereoscopic views the size and location of intrapelvic organs and growths may be determined; however, in most cases a flat plate will give the information desired.

Credit for the initial work in this country goes to William Cary,[2] who in 1914 reported radiographic studies of the uterus and tubes, using collargol as the contrast medium. Shortly thereafter Rubin[10] published his first work along the same line. Since then many advances in technique refinement and radiopaque substances have been made, the most significant of these being the introduction of lipiodol by Heuser in 1921. All materials used previously had caused marked peritoneal irritation when extruded from the tubes. The test is now generally considered to be a relatively safe and simple procedure.

The commonly accepted contraindications are genital infections, pregnancy, and vaginal bleeding. Miller[7] attributes most of the febrile reactions to failure in recognizing cervicitis or incompletely subsided salpingitis. In a survey of the literature Feiner[4] found an average morbidity of 0.5 per cent in 13,424 cases following utero-salpingography. This is approximately five times greater than the reported morbidity following tubal insufflation.

Most observers agree on the first week after menstruation as the optimum time for the test, particularly when information concerning tubal patency is desired. Hysterograms can be made at any time during the cycle except when active bleeding is present.

FIG. 1. An essentially normal uterosalpingogram with a symmetrical uterine cavity and the opaque media appearing as droplets within the peritoneal cavity.

FIG. 2. A large cyst of the cervix, also a defect of the fundus and occlusion of the tubes at either cornu.

Our technique has no essential differences from that which has been described numerous times in current literature. We usually use a Colvin screw-type canula, through which the contrast medium is injected. There are a number of iodized preparations available for this purpose but for most studies we have used lipoiodine. This material is preferred because it is readily absorbed and apparently less irritating to the tissues. It is rare to find any roentgen evidence of this substance remaining in the tissues longer than a few hours following its use. It is slowly instilled under fluoroscopic visualization and films

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are made immediately thereafter. Frequently, during examinations for tubal patency, these plates will reveal some of the medium in the peritoneal cavity that could not be detected by fluoroscopy. When one of the more slowly absorbed materials has been used (lipiodol, skiodan-acacia, and so forth), recheck films after a twenty-four hour interval may give added information where tubal patency is questionable.

CASE ILLUSTRATIONS

Figure 1 shows an essentially normal uterosalpingogram with visualization of a symmetrical uterine cavity, both tubes in their usual relationship with surrounding structures, and the opaque medium within the peritoneal cavity proving tubal patency.

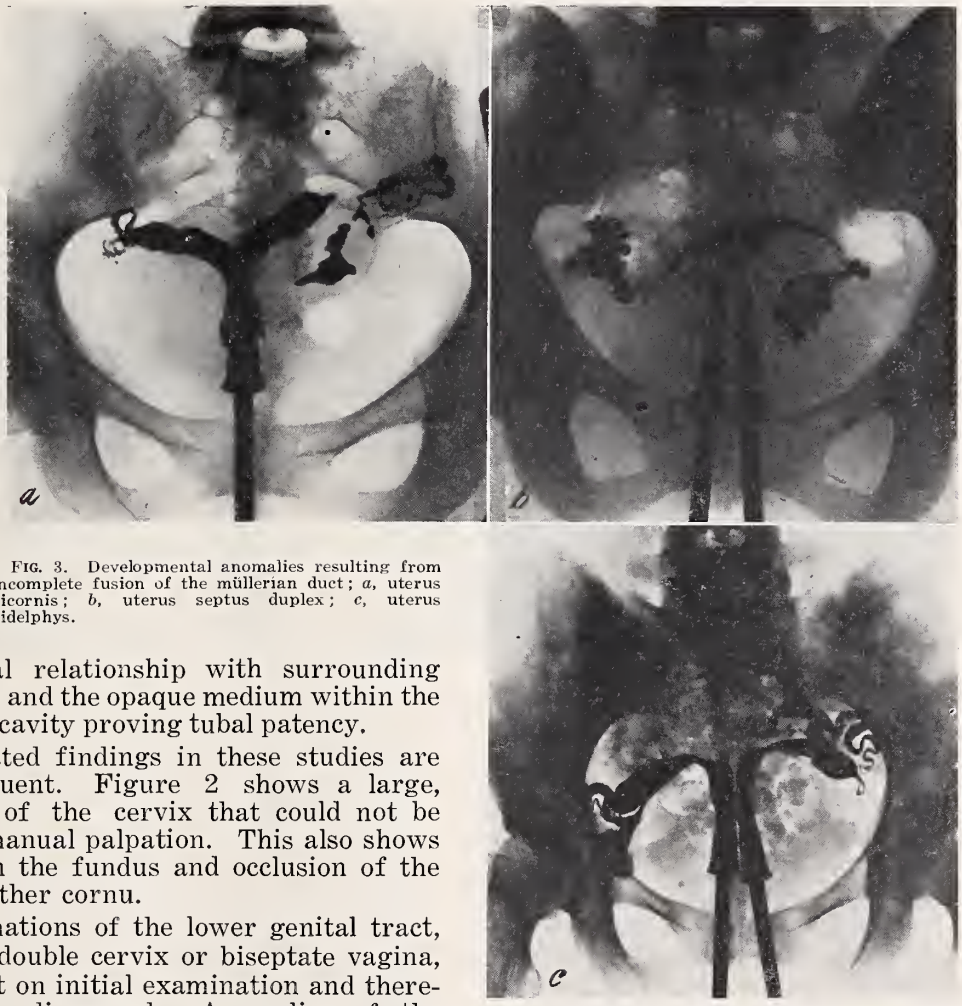

FIG. 3. Developmental anomalies resulting from incomplete fusion of the müllerian duct; *a*, uterus bicornis; *b*, uterus septus duplex; *c*, uterus didelphys.

Unexpected findings in these studies are not infrequent. Figure 2 shows a large, soft cyst of the cervix that could not be felt on bimanual palpation. This also shows a defect in the fundus and occlusion of the tubes at either cornu.

Malformations of the lower genital tract, such as a double cervix or biseptate vagina, are evident on initial examination and therefore easily diagnosed. Anomalies of the upper tract, on the other hand, may remain obscure until accidentally found by roentgen studies. Figure 3 shows varying degrees of the same deformity from a uterus bicornis to a complete didelpys with double vagina, all resulting from incomplete fusion of the müllerian ducts. The patient of this figure complained of sterility and severe dysmenorrhea. No improvement was obtained by a prolonged period of office treatments and a presacral sympathectomy was advised as a last resort. At operation the left uterus showed very poor muscular development and was removed. The thick vaginal septum was excised at the same time. She subsequently became pregnant and delivered spontaneously.

Figure 4 illustrates a filling defect in the right uterine cornu which proved to be a sessile polyp. The patient complained of postmenopausal bleeding. At the time of the initial examination a small polyp was found in the cervical canal but this did not appear to be the source of the bleeding. Although the underlying pathologic condition in this case was shown by roentgen study, curettage was indicated not only to remove the fundal polyp but also to rule out the possibility of associated malignancy of the endometrium. Cure was effected by thorough curettage and radium therapy.

Figure 5 shows distortion of the uterine

cavity by a large fibroid. Such studies are occasionally of value in differentiation of various intrapelvic tumor masses. With smaller tumors such information is often very helpful in determining whether a myomectomy can be done in women who are desirous of retaining their capacity for future pregnancy.

Occlusion of the isthmial portion of both tubes is shown in figure 6. Prior to arriving at such a diagnosis it is necessary to rule out tubal spasm, which may produce an apparent occlusion. In cases of this type Victor Bonney[1] and Green-Armytage[5] have reported a high percentage of pregnancies following intra-uterine transplantation of the tubes. Most observers, however, do not feel that this procedure is sufficiently successful to justify the operation. This patient had no complaints other than sterility and was advised to adopt a baby.

Figure 7 shows an example of chronic bilateral hydrosalpinx. This is not an uncommon condition in sterility cases with a history of previous infection. After the usual precautions to determine that the infection had completely subsided, this patient had several unsuccessful attempts to insufflate the tubes with carbon dioxide. A salpingogram was then done and a small amount of the opaque medium can be seen in the peritoneal cavity. When subsequent insufflations were done the gas passed easily at 70 mm. mercury pressure. This is a good example of the therapeutic value of iodized oil in breaking up fimbrial adhesions which had caused complete tubal occlusion. The goal of pregnancy was eventually reached by this patient but it was not of a desired type. Approximately eight months later a laparotomy was performed for a right ectopic gestation. After amputation of the distal third of the right tube a cuff-type plastic procedure was done on the remaining portion. Inspection of the left tube revealed a healed inflammatory process in which fimbrial occlusion had persisted. Insufflations were again instituted a few weeks after operation and the gas passed freely at 80 mm. mercury pressure. The patient is still making every effort to become pregnant.

Fimbrial occlusion of the tubes can be surgically corrected in a much higher percentage of cases than interstitial obstructions, and is a justifiable procedure in certain well selected patients. It is particularly important that any such operative measure be preceded by salpingography to ensure patency of the tubes, other than at the fimbrial end. It is equally important to institute postoperative insufflations as early as possible to prevent recurrence of the obstruction.

Figure 8 shows an example of intravasation of the opaque medium into the uterine bed and lateral pelvic veins. After several unsuccessful attempts to insufflate the tubes a uterosalpingogram was done using 10 cc. of lipiodine. The material passed easily into the uterine cavity and between 3 and 4 cc. was recovered. The patient experienced no reaction other than a slight cough. A roent-

FIG. 4. Filling defect in the uterine fundus produced by a sessile polyp.

FIG. 5. Distortion of the uterine cavity by a large fibroid.

genogram of the chest was immediately made and it showed no evidence of the opaque medium in the lung fields. A roentgen study of the pelvis two hours later revealed almost complete disappearance of all the opaque material except for small amounts in the uterine wall.

The case report of fatality immediately following uterosalpingography which occurred in the series of one of the authors (A. L. M.) is submitted:

CASE REPORT OF A FATALITY

A 35 year old white woman was first seen in March, 1945, because she had been unable to conceive during her ten years of marriage. She gave a history of pelvic infection fifteen years previously which required her to remain in bed for three months because of pain and fever. There had been no recurrence of these symptoms and she had no complaint other than sterility.

Her general physical examination was essentially normal. On speculum visualization the cervix was found to be smooth and normal. The uterus was anterior, freely movable, and not enlarged. There were no adnexal masses or areas of tenderness on either side.

During the next two months three unusuccessful insufflations were attempted. On May 21, a uterosalpingogram revealed occlusion of the tubes at each cornu. There were no reactions following the injection of gas or iodized oil; however, the patient complained of marked pain each time the canula was inserted in the cervix. She was told that her chances of becoming pregnant were practically negligible but she insisted that further studies be made. Three months later, on September 11, another attempt was made to pass opaque medium through the tubes. On this occasion she was given approximately ten minutes of light cyclopropane anesthesia to eliminate the severe pain she had experienced with previous tests. Twelve cc. of lipoiodine were slowly instilled into the uterine cavity and stereoscopic roentgenograms taken. About 3 cc. was recovered when the canula was removed. The material passed into the cavity very easily.

Her condition remained good until eight minutes later when she rapidly developed a grayish pallor while being transported to her room. Simultaneously the pulse became very weak and she died within the next five minutes. Stimulants, oxygen, and artificial respiration were used to no avail.

The stereoscopic roentgenograms clearly show the medium filling numerous small veins throughout the uterine wall, as well as the large veins laterally (fig. 9). These roentgenograms taken about thirty seconds apart, show the lipiodine coursing upward in the large veins.

Postmorten roentgenograms of the abdomen, chest, and head were taken four hours later and no abnormality or trace of the medium could be found in any of the films.

Unfortunately an autopsy was not done. A permit for that examination was obtained but the body was removed from the hospital before it could be performed.

Fig. 6. Occlusion of the proximal end of both tubes.

Fig. 7. Fimbrial occlusion of the tubes with hydrosalpinx.

DISCUSSION

In a review of American literature, only 1 other death following uterosalpingography was found. That was reported by Feiner[4] in 1942, the result of generalized peritonitis fourteen days after the test. He cited 8 other deaths that had been reported in Europe by Gauss and Schultz but the exact circumstances of these could not be learned since the articles are not available.

There have been a number of published cases of intravasation of iodized oil into the pelvic veins but in most instances no ill effect resulted. It was observed 18 times by Robins and Shapira[8] in a series of 1,000 uterosalpingograms, and the only aftermath was a slight leukocytosis. In 1930 Witwer and his associates[13] reported 2 cases and suggested an abnormal permeability of the endometrium as the cause. Meaker[6] in 1934 reviewed 10 cases from the literature along with 1 of his own and mentioned two possible explanations: first, a dissolution in the continuity of the endometrium; second, ex-

cessive pressure forcing the medium through the epithelial layer. In his case a pressure of 300 mm. of mercury had been used. Such an explanation would appear logical but several writers have shown that this is not al-

FIG. 8. Extensive intravasation of radiopaque medium into the uterine bed and pelvic veins which produced no symptoms other than a slight cough.

ways true. In one of Witwer's cases intravasation occurred at a low manometric pressure. Other examples have been reported

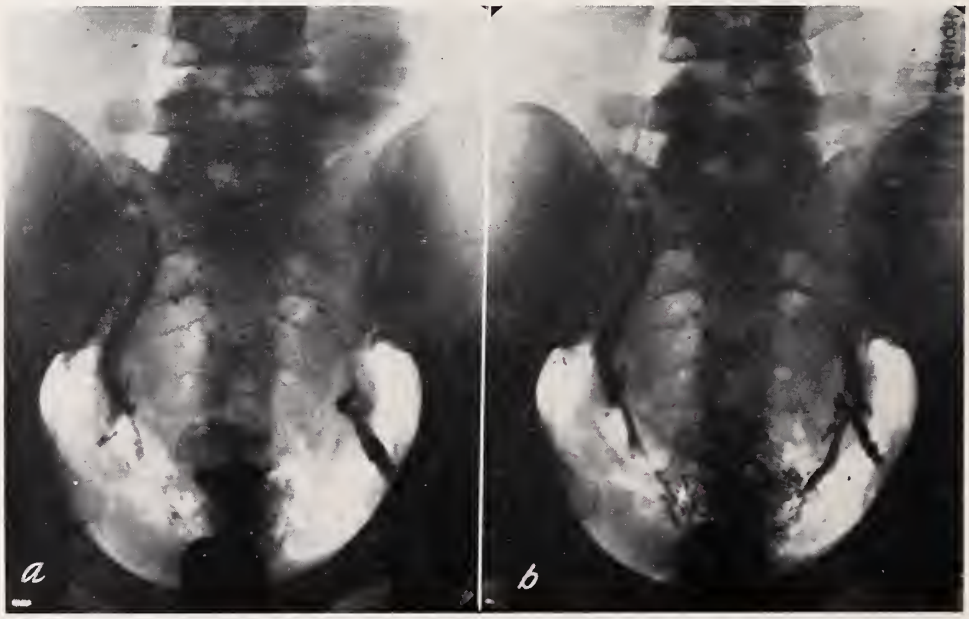

FIG. 9. Stereoscopic films of a case of fatal intravasation of the opaque media taken approximately 30 seconds apart; *a* shows the material filling numerous small veins throughout the uterine wall and the large veins laterally; *b* shows further distention of the vessels with the lipoiodine coursing upward.

which lend strength to the theory of increased permeability of the uterine vessels.

As an experiment, Sicard and Forrestier[11] in 1923 observed the results of lipiodol (2 to 4 cc.) which was slowly injected in the cubital vein. Through roentgen studies they found that the substance rapidly reached the pulmonary capillaries in small droplets and was completely absorbed within ten minutes. The patient had no symptoms other than a slight cough.

Walther[12] in 1939 studied the same problem by means of animal experimentation and found that the iodized oil was split into its principal substances of iodine and oil within the pulmonary capillaries. The former was excreted as potassium iodide through the kidneys in six to eight days. The oil was removed by blood lipases and by absorption of the lung tissue cells which contained it.

In a recent survey of techniques used by various gynecologists, Eisen and Goldstein[3] found that the majority used 4 to 8 cc. of iodized medium for uterosalpingography. Some used as much as 20 cc. for a single injection. They concluded that the amount of material used had no bearing on intravasation but when it occurred, the resulting symptoms varied directly with the volume which reached the blood stream. Their report included a case of extensive venous intravasation where 15 cc. of lipiodol was used. Pulmonary complications resulted in the form of emboli with pneumonitis and actual infarction. The patient recovered within a month.

A similar accident was reported by Roblee and Moore[9] in which intravasation was pro-

duced when 9 cc. of lipiodol was used at a pressure of 140 to 150 mm. of mercury. Approximately 5 cc. of the material entered the venous system. Pulmonary emboli were demonstrated shortly thereafter but the patient developed no symptoms other than a mild cough and slight hemoptysis. Most of the oil had disappeared from the lung fields within twelve days.

In evaluating the case which has been presented, the cause of death remains a matter of speculation. Intravasation did not occur with the first hysterogram and the pressure used during the second was, if anything, considerably less. The reason for using as much as 12 cc. of lipiodine during the last study was the ease with which it entered the uterine cavity. It would seem likely that this accident was produced through injury to the cervical canal by the canula, or that the anesthetic played some role. Admittedly, anesthesia is seldom, if ever, indicated for such a procedure. Both tests were done during the first week following menstruation; therefore, the state of the endometrium should have been essentially the same each time.

The possibility of a fatal embolus was fairly well ruled out by postmortem roentgen studies showing the lung fields and brain to be entirely free of any demonstrable foreign material.

The most probable cause of death would seem to be a sudden reaction to the iodized oil. Although she had no symptoms from the first injection, it may have sensitized the patient to such an extent that the second amount proved fatal when it reached the blood stream.

CONCLUSIONS

1. The use of uterosalpingography has been shown by numerous investigators to be a valuable aid in the diagnosis of many obscure problems encountered in gynecological practice. Some of its uses have been demonstrated in this presentation.

2. The contrast medium should be injected slowly and the amount limited to the minimum quantity necessary to demonstrate the pathologic condition usually 5 to 6 cc.

3. Anesthesia is rarely if ever indicated, and should be avoided.

4. It is a procedure which should not be considered as entirely safe and harmless, as some writers have suggested, since it entails a definite morbidity and mortality hazard, even though relatively small.

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X-RAY EXPOSURE METERS AND AUTOMATIC EXPOSURE TIMERS

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This paper will describe x-ray exposure meters and automatic exposure timers, not so much from the standpoint of their clinical use, but from the fundamental physical and electrical principles underlying the function of these two types of apparatus. Practicing roentgenologists today have so much clinical medicine to learn that they do not have the time to go into the electronic background of such instruments. These fundamentals will be explained as simply as possible.

The importance of correct exposure of x-ray films is obvious to any roentgenologist. Estimation of diagnostic x-ray exposure is made usually by measuring the thickness of the anatomical part under consideration and by adjusting the time or kilovoltage according to a chart. However, x-ray exposure is influenced not only by the thickness of the part but also by its density, which varies widely under normal and pathologic conditions. For example, an adipose woman may measure the same as a very muscular man; yet the density of the man's tissue will be much greater than the woman's. It has been the mark of a good technician to judge correctly such differences in tissue density, but at times even the best technician fails to do so properly.

If the effective intensity of x-ray radiation that is received at the plane of the film after it has traversed an anatomical part could be precisely measured, it would be a very simple

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matter to calculate the proper exposure time. If an instrument could be devised in which a meter actually registers such x-ray intensity, the reading of this meter could be converted easily to a setting of either time or kilovoltage, or both, that would assure a proper exposure of the film. Such a device would be an x-ray exposure meter. Several such exposure meters were produced commercially on the European continent before the war. These instruments were rather low in sensitivity and were not very stable. It remained for Morgan in this country to design the first successful, sensitive, and easily used x-ray exposure meter. Morgan has not only perfected this type of instrument, but has also designed a very successful automatic exposure timer.

It should be pointed out that there is quite a difference between these two instruments. An x-ray exposure meter is a device used to measure the intensity of radiation after it has passed through an anatomical part. The instrument is placed in relation to the patient in the same plane the x-ray film would be normally, and then a test exposure is made. The intensity of roentgen rays falling on the plane of the film is indicated on a meter dial, and the settings of the x-ray machine are made from the readings on this dial. This type of meter is similar in function to the ordinary photographic exposure meter used to determine settings for a camera. This latter instrument is aimed at the scene to be photographed, and the intensity of light coming from the scene is indicated on a meter, thus determining the proper exposure for setting the camera shutter and diaphragm.

The use of the x-ray exposure meter calls for one preliminary trial exposure to ascertain the correct setting of the x-ray machine for making the actual roentgenogram. The automatic exposure timer developed by Morgan does not require this preliminary exposure. Morgan's device measures the amount of x-ray that passes through the patient, casette, and film, and it stops the exposure after a proper amount has reached the film, thereby replacing the mechanical or electrical timer commonly in use now.

The fundamentals underlying the x-ray exposure meter will be considered first. This instrument is composed of comparatively simple elements. Its construction is complicated moderately by the fact that one is dealing with extremely small currents and a great amount of amplification is necessary to make these currents readable on a simple rugged meter. Its fundamental parts are a fluoroscopic screen, a photoelectric cell, a direct current amplifier, and a microammeter.

A photoelectric cell is an electronic vacuum tube, containing a cathode and an anode. The cathode, which is usually a large curved surface in the typical photoelectric cell, is covered with a complex coating which emits electrons when struck by photons of light. This function is similar to the cathode in an x-ray tube, which produces electrons when the filament is heated by an electrical current. These electrons are collected on the anode, which is usually a small cylindrical post or wire, placed at approximately the focus of the curved cathode. Just as in an ordinary x-ray tube, it is necessary to have a positive potential on this anode to draw the electrons from the cathode. This positive voltage, however, instead of being many thousand volts, as in an x-ray tube, is only a few volts. In the high vacuum type of photoelectric cell, the voltage may be as low as 15 volts or even less. The number of electrons displaced from the cathode is directly proportional to the intensity of the light falling on the sensitive surface. Therefore the current flowing through a cell will be directly proportional to the intensity of light illuminating the cell. This holds true over rather wide ranges of light intensity.

The sensitive cathode coating on different cells responds to different spectra of light, and the maximum sensitivity of a cell can be placed almost anywhere in the spectrum from the near infrared through visible light to the near ultraviolet by selecting the proper cathode coating. Until the type 929 photoelectric cell was developed with a cathode highly sensitive to blue light, no photoelectric cell would give a sufficient response to the illumination from a fluoroscopic screen to be used satisfactorily in an x-ray exposure meter. The current produced was so small that an amplifier to make it readable was unstable. The 929 photoelectric cell, however, has its maximum sensitivity in the spectral region where intensifying screens fluoresce. It also has a spectral sensitivity curve that parallels closely the curve of ordinary x-ray film. Even then, the amount of current produced by this cell is very minute when illuminated by a fluoroscopic screen, activated by the small amount of roentgen rays that have passed through the patient's body. This current is too small to be measured by any instrument except an extremely sensitive galvanometer. Such an instrument is impractical for use in the ordinary x-ray laboratory, and for practical use this current must be amplified by a direct current amplifier.

The subject of direct current x-ray amplifiers is an extensive one. The principle by which most highly sensitive direct vacuum tube amplifiers work is the utilization of the voltage drop that a small current will produce

across a grid resistance of extremely high value. This voltage drop is impressed on the grid of the amplifier tube, thereby effecting large changes in the plate current of the tube.

According to Ohm's law, the voltage drop across a resister is equal to the current multiplied by the resistance, the current being expressed in amperes and the resistance in ohms; thus, for example, if 1 milliampere (1/1,000 of an ampere) of current flows through a resistance of 1,000 ohms, the voltage drop will be 1 volt. If 1 microampere (1/1,000,000 of an ampere) flows across a resister of this value, the drop will be only 1/1,000 of a volt. The current produced by a photoelectric cell excited by the light from a fluoroscopic screen is in the order of 1/1,000 of a microampere. To produce sufficient voltage drop to activate the grid of an amplifier tube, it is necessary that this current flow through a resister of extremely high value. The resisters that are used in direct current amplifiers to measure small currents, therefore, range in value from around 100,000,000 ohms to a thousand thousand million ohms. It can be seen that if a current of 1 billionth of an ampere flows across a resistance of 1 billion ohms, the voltage drop will be 1 volt. A change of 1 volt on the grid of a vacuum amplifier tube can cause a marked change in its plate current.

A typical vacuum amplifier tube is a triode, or one that contains three elements—a filament, a grid, and a plate. The filament is heated by an electrical current and throws off electrons. The plate of the tube is charged with a positive voltage which will draw these electrons to it, thereby creating a flow of current. The grid is located between the filament and the plate. If a negative charge is placed on this grid, it will tend to repel the negatively charged electrons flowing from the filament to the plate, thereby reducing the flow of current. The amount of reduction in flow varies with the degree of negative potential on this grid, and small changes in this potential alter greatly the plate current.

An ordinary vacuum tube cannot be used very satisfactorily in direct current amplifiers for minute currents because there is a considerable flow of current through the grid itself. This current is caused by collection on the grid not only of electrons but also of positive ions, which normally exist in the average vacuum tube. This current is unimportant in the ordinary application of vacuum tubes, but if the resistance in the grid circuit amounts to a thousand or more megohms, it will cause a marked voltage drop across this resister, thereby affecting the grid bias. Hence, in order to measure the minute current flowing from photoelectric cells, it is not only necessary to have a very high value grid resister in the vacuum tube circuit, but also to have a vacuum tube that draws a very minimal amount of grid current. Such tubes are known as electrometer tubes. Low grid current is achieved in electrometer tubes by special physical construction and by use of low voltages on the electrodes. The usual plate voltage is from 6 to 12 volts.

The next part of the exposure meter is the recording meter itself. This usually is an ordinary microammeter with a full scale range of 50 to 200 amperes, depending on the amplifier tube. The meter is inserted in the plate circuit of the amplifying tube. The plate current, even in an electrometer tube, may be as high as 500 microamperes, which is several times the amount of current that this meter will carry. To use a microammeter in the plate circuit of such an amplifier, it is necessary to use a bucking current across the meter. This is done by means of a battery and a variable resister, which are shunted across the meter in such a fashion that the current from the battery through the resistance flows through the microammeter in a direction opposite to the flow of plate current. By adjusting the variable resister, the meter current can be "bucked" back to zero, even though a current of 3 or 4 milliamperes is flowing in the plate circuit. A small change in the grid potential of the tube will then give a large degree of registration on the microammeter.

It is necessary to have a sensitivity control in the x-ray exposure meter, which is best accomplished by shunting a variable resister across the microammeter itself. This shunt will increase or decrease the sensitivity of the meter by rotation of the control knob of the variable resister. The resister control can be calibrated for different sensitivities to meet varying conditions encountered in the actual use of the meter, such as variation in speed of screen, of film, and of changes in developing solution.

The last part, and one of the most important, of the exposure meter is the flouroscopic screen. Roentgen rays directly affect photoelectric cells only to a very small extent. It is therefore necessary to convert the energy of roentgen rays into some form of radiant energy to which the photoelectric cell is sensitive. Morgan showed in a series of experiments that the Patterson Type B fluoroscopic screen was not only the most efficient in converting roentgen rays into blue light, but also that this screen, when used to activate a 929 photocell, had a sensitivity to roentgen rays that paralleled that of x-ray film exposed with intensifying screens. A

slight difference between the sensitivity of Patterson B screen to different kilovoltages from that of x-ray film can be corrected by the addition of 0.5 mm. of aluminum filter between the fluoroscopic screen and the anatomical part of the patient. For use with nonscreen films a fluorozure screen must be employed.

The complete exposure meter therefore works as follows: The fluoroscopic screen of the x-ray exposure meter is placed in the plane to be occupied later by the film. The patient is placed as though an actual x-ray exposure were to be made, and a trial exposure is made with a predetermined standard kilovoltage, milliamperage, and time. With the x-ray exposure meter I use, the test setting for a chest plate is approximately 50 kilovolts, 200 milliamperes, .2 of a second at six feet. An exposure is then made. This causes a fluorescence of the screen. The light from the screen impinging on the photoelectric cell causes a minute current to flow across the grid resister of the electrometer tube. This minute current, flowing across the high grid resistance, will produce a voltage drop of several tenths of a volt. This drop will make the grid of the electrometer tube more positive by that amount. This change in grid voltage will cause a large variance in the plate current, which will be read on the microammeter.

The meter is calibrated for actual use by trial exposures. The type of exposure meter mentioned has been rendered somewhat obsolete by the introduction of a new type of photocell, known as a multiplier photocell. This cell has obviated the necessity for an electrometer tube with its somewhat unfavorable characteristics. The principle of the new photocell is as follows: The tube consists of a sensitive photoelectric cathode sealed in the same envelope with an electronic multiplier arrangement. This consists of a series of anodes or dynodes arranged obliquely with reference to each other so that when an electron is freed from one dynode, it is drawn to the adjacent dynode at rather high velocity. The first dynode of this multiplier system faces the photosensitive cathode and has a positive potential of 50 to 100 in relation to it. When one electron is removed from the photosensitive surface by a photon of light, this electron is drawn to the adjacent dynode by the reasonably high potential existing between the dynode and cathode. The electrode is accelerated to a considerable velocity, and when it strikes the dynode it causes the emission of several secondary electrons from the dynode itself. These several electrons are drawn then to the next succeeding dynode, which is charged with a potential of 50 to 100 volts higher than the first. Each one of the electrons as it reaches the second dynode will in turn dislodge several more secondary electrons. These electrons are then drawn on to the third dynode by the same difference of potential as exists between the first and second dynodes. In this way, with each electron producing several secondary electrons when it strikes the next succeeding dynode, one electron that leaves the photosensitive cathode is multiplied to many hundred thousand electrons by the time it reaches the final electrode. Various type cells have from six to twelve of these accelerating dynodes. The best known of the multiplier photocells is the R.C.A. 931, which has nine anodes. This tube when used with 100 volts on each anode has an amplification factor of around 200,000. It is very stable and can be made to produce a high current output when used in simple circuits. It is not available to the general public as yet, but it should be within a few years.

Although the x-ray exposure meter described is a valuable instrument and still has many uses in radiology, it is not as important as the automatic exposure meter developed by Morgan. This instrument requires no trial exposure and actually terminates the exposure to an x-ray film after the correct amount of roentgen rays have reached it. The basic vacuum tube around which the timer is built is the multiplier phototube already described. The phototimer circuit includes the following component parts: A fluoroscopic screen, a multiplier phototube with power supply, a thyratron vacuum tube, and various relays. The fluoroscopic screen, along with the multiplier phototube, is mounted behind the film casette and therefore receives radiation after it has passed through the patient and through the casette. The filtration produced by the casette with its films and screens changes the quality of the rays which strike the fluoroscopic screen of the timer unit. It was found by Morgan that the Patterson type B screen was not satisfactory for use with this timer because of the filtration effect but that a fluorazure type screen did give a proper response.

The next component part of the timer to be considered is the thyratron, or gas-filled vacuum tube. This is quite different from the ordinary radio tube and is primarily designed to carry large amounts of current. There are many varieties of thyratons filled with various gases under low pressure. This pressure, however, is much higher than in the ordinary vacuum tube. The gas will ionize under certain conditions and, because

of this ionization, can carry large amounts of current between the electrodes of the tube. The cathode of this tube differs somewhat from the one in ordinary radio tubes in that it is designed to give off much larger numbers of electrons.

The tube works as follows: If the grid is biased quite heavily negative and a moderate potential is applied between the cathode and anode, no current will flow. If the grid is gradually made more positive, at a certain point a few electrons will flow from the cathode to the anode. These electrons develop considerable kinetic energy as they are accelerated by the voltage on the plate, and in traversing the space between the filament and plate they will strike molecules of the gas in the tube. When one of these electrons strikes a molecule of gas it will displace an electron from the molecule, thereby ionizing the molecule. The displaced electron becomes the negative ion, and the remainder of the molecule becomes the positive ion. The displaced electron, or negative ion, is then drawn toward the positively charged plate. The heavier positive ion is drawn toward the negatively charged cathode. Each one of these ions, in traveling to its respective electrodes, will strike other molecules of gas and ionize them. The process described occurs very rapidly, and within a few microseconds a tremendous number of ions are formed; these ions, traveling to their respective electrodes, carry the current across the tube. The beginning of the discharge is called "firing" the tube. After the tube is fired, it will continue to carry current, regardless of the charge on the grid, until the voltage on the electrodes drops below a certain point, at which time the discharge is extinguished.

In the usual circuit, the tube is activated by an alternating current so that the plate is positive for one hundred twentieth of a second and in the next one hundred twentieth of a second it is negative. The tube will carry current during the period the plate is positive, but during the next period, when the plate is negative, no current will flow. If during this phase the grid becomes sufficiently negative, no current will flow when the plate becomes positive again. There is only a small flow of current in the grid circuit; thus in a thyratron tube only a small amount of power on the grid can control a great amount of power in the cathode plate circuit.

In the automatic exposure timer, the grid of the thyratron is connected to a condenser, and both are charged continuously to a certain negative potential. When the x-ray exposure is made, a relay disconnects the charging current from the grid and its condenser. Ordinarily the charge on this condenser would leak away slowly, and eventually the grid of the tube would become positive enough for the tube to fire. Usually this leakage would take place over a period of several seconds. In the phototimer, however, the condenser is discharged much sooner than this by the flow of current through the photoelectric cell. The cell starts to conduct current as soon as the x-ray exposure starts. The magnitude of current flow and, therefore, the rapidity of the discharge of the condenser depend upon the intensity of illumination of the fluoroscopic screen. After a certain amount of discharge through the photoelectric cell, the potential of the condenser and, therefore, the grid, become positive enough that the thyratron tube will fire. The current through the thyraton tube is heavy enough to operate a husky relay which opens the x-ray exposure circuit, thereby terminating the exposure.

The actual construction of the photoelectric timer is much more complicated than the simple circuit described. To date the most important application of photoelectric timers has been in radiography of the chest, particularly in mass radiography. The efficacy of the photoelectric timer has reached its maximum, however, in photoroentgenography. In this application, the photocell is not mounted behind the film as it is in conventional radiography, but in the hood of the photoroentgen camera in such a manner that a small lens focuses an image of a portion of the intensifying screen on the sensitive surface of the cell.

Morgan has pointed out that if exposures are exact enough, wide variations in kilovoltage may be used for radiography of the same part with relatively little difference in the appearance of the finished film. In photoroentgenography, an arbitrary kilovoltage of 80 to 90 kilovolts, for instance, is selected and all exposures are made at that kilovoltage. The photoelectric cell then adjusts the time of the exposure until the proper film density is obtained. It is amazing to view a large number of these fluorographic films made on subjects of varying size and see how nearly alike large strips of film will appear. This marked homogeneity of exposure density makes reading of photoroentgen films much easier than when there is rather wide variation in the density of the films.

I have had no experience with the use of the phototimer in parts of the body other than the chest. Morgan has described such an instrument, but just how well this works I do not know.

SUMMARY AND CONCLUSION

The fundamental principles underlying the functioning of x-ray exposure meters and

automatic x-ray exposure timers have been outlined. Some of the uses of these instruments have been discussed, and the value of automatic exposure control in photoroentgenography, in particular, has been stressed.

X-ray exposure meters and automatic x-ray exposure timers represent a distinct advance in the technique of roentgenology.

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PROBLEMS OF CONGENITAL CATARACTS

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The Texas School for the Blind is the assembly point for all the blind, or partially sighted, children in Texas between the ages of 6 and 21 years. Here these children are educated and rehabilitated as much as possible by surgical and medical means. The cataract group of children has to be divided into three classes: (1) those who have been unsuccessfully operated on for congenital cataracts prior to their entry into the school; (2) those who have had surgery prior to entry but on whom more surgery is necessary in order to improve their vision; and (3) those who have had no surgery.

I have had the opportunity of observing these cases for nearly twenty years, and my purpose in this paper is to discuss briefly the various types of complications found in the children who have had surgery prior to admission to the Texas School for the Blind; to conjecture on the reasons for these complications; and to present briefly the plan or procedure which has been used successfully in the school.

At the present time there are 30 to 35 children with juvenile cataracts (congenital) in the school; that includes all the groups mentioned above. I shall now take up the first group—those who have developed complications following surgery prior to their admission into the school. I know of no condition that has caused more heartaches to some of the best ophthalmic surgeons in this part of the country than a few of these cases of congenital cataracts. It has also been my experience and observation that the number of cases that each ophthalmologist sees each year in his private practice is small. The over-all number of cases in the school confirms this observation. I think that the surgical procedure being so simple is another cause for the bad results; the cases are just not taken seriously enough.

The cases where the pupil is very eccentric as a result either of posterior adhesions to the remnant lens capsule, or anterior synechia caused by incarceration of the iris in the corneal wound are quite common. The eccentricity of the pupil, provided that there has been no serious other complications like uveitis, is no tremendous reason for worry. Surgery can correct many of these defects, or, if there is a clear pupil, it is wiser to leave them alone.

We frequently see cases in which the pupil is round and dilates freely and widely, but there is a dense piece of lens capsule with some cortex in the center of the pupil. A linear incision through the cornea at the limbus and a pair of iris forceps will remedy this situation. It might be wiser in some cases to do an iridectomy prior to grasping the capsule, because there might be adhesions between iris and capsule which cannot be seen. It is imperative that gentleness be the keyword.

The above mentioned complications are not particularly serious. They can happen without the patient's losing his eye. However, when the patient develops an acute glaucoma because the lens substance swells too much after a discission, it is imperative that a linear incision be done immediately, that the soft substance be washed out and as much of the capsule be withdrawn as possible.

We see cases where the tension does not become elevated but the patient develops a severe uveitis. If the lens substance is allowed to remain, the eye is frequently lost. In these cases the iris may or may not become bound down completely, with little or no pupil, or the eye may develop a hypotension and ultimately lose all sense of light perception. When this stage has developed, the globe may just become atrophic, or it may shrivel up until there is a pthisis bulbi.

One other serious complication following a severe uveitis is a hypertension with a staphyloma of choroid and sclera developing. These cases are distressing because the patient is not only blind, but also has a misshapen eyeball which gives a bad cosmetic appearance.

What are the reasons behind these complications?

1. I think that one of the main reasons is that the parents of these children are not financially able in many instances to permit the patient to remain in the hospital for a

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sufficient period of time. These patients should be kept quiet and under observation in a hospital for ten days to two weeks at least and frequently much longer. That prerequisite is difficult for the average family. The period of observation postoperatively is much longer.

2. The young eye is treated in the same fashion as the adult eye, that is, the same procedure is used as in expressing a senile cataract. That is very dangerous, and it should not be done.

3. The use of a general anesthetic is necessary for small infants and refractory young children, though we never use it at the school. All discissions are done under 5 per cent cocaine anesthesia. Our results under local anesthesia have been excellent.

4. The pupil may not have dilated adequately, and therefore when the soft substance of the cortex begins to swell, increased pressure develops. Further surgery is imperative. If the pupil does not dilate well, an iridectomy should be done first, the eye allowed to heal, and a discission performed later.

5. A very common procedure and one that is frequently advocated is that a large, deep incision be made through the capsule at the time of the initial operation. This incision may be cruciate, or any shape that the operator desires, but the result is that the cortex swells so rapidly the aqueous humor cannot carry it away fast enough, and a severe uveitis plus increased tension develops.

6. The one procedure that I think is reprehensible and that is done not infrequently, if our records are correct, is for the surgeon to operate on both eyes simultaneously. I think that is the one procedure which cannot be excused. It is very dangerous and both eyes may be lost. This point cannot be stressed too emphatically.

Now I shall outline briefly the procedures used in some 75 cases that have been operated on in the Texas School for the Blind.

First of all, when shall the operation for cataract be performed? If the patient is an infant, with large dense, diffuse lens changes, it is wise to operate early, but a small incision through the lens capsule should be made the first time. If the opacity of the lens is small, with plenty of clear lens substance, it is better to wait a few years before operating.

If there is a dense capsule remaining after a conservative incision through the capsule, a linear incision should be made at 12 o'clock through the limbus. An iridectomy should be performed first, then the lens capsule pulled out with an iris forceps. If the child has previously been operated on and there is a very dense capsule with iritic adhesions, a capsulotomy may be done.

In the case of a patient who has never been operated on before, we anesthetize the eye with 5 per cent cocaine hydrochloride after the pupil has been widely dilated with atropine. The capsulotome is then introduced through the outer one-third of the cornea, and a cruciate incision is made. The size and length of the incision both in the horizontal and vertical planes depends on (1) the width of the pupillary dilation, and (2) the type of the cataract. The soft cortical opacity gets the smaller incision, as the aqueous humor causes too much swelling and inflammation. If the tension becomes elevated, a linear incision is made and the lens contents are washed out with normal saline solution. An iridectomy may be done at this time if necessary. However, we advocate doing as little surgery as possible, handling and manipulating the eye as gently as possible. Following the operation, 1 per cent atropine is instilled and both eyes are dressed. The dressings are kept on both eyes for three or four days, longer if necessary. One per cent atropine is instilled three times daily beginning the day following the surgery. The patient is confined to the hospital ten days to two weeks.

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ABSTRACT OF DISCUSSIONS

Dr. A. E. Jackson, Fort Worth: Because of his connection with the Texas School for the Blind for a number of years, Dr. Hilgartner has had the unusual opportunity of observing these unfortunate blind children and has brought us a valuable composite picture of his observations and, incidentally, probably has accounted for some of the patients we have operated on and have lost sight of. The problems to be encountered in the management of congenital cataracts are many and varied depending upon the type and degree of the capacity, the age when first seen, whether unilateral or bilateral, and development of the child. Unfortunately, my limited experience indicates that a number of these children have other congenital defects, that is, subnormal mentality and development. It is this type in which the ophthalmologist needs the assistance of the pediatrician and neurologist and he should always give a guarded prognosis, for stranger things have happened in medicine than blaming the imbecility of a child on the cataract operation.

A baby born blind from congenital cataracts is usually not suspected by parents until the age of 4 to 6 months when the parents or toys are not recognized. Since vision is an essential of normal mental development, it is my custom to begin discission soon after the first birthday, one at a time under ether anesthesia, only after the pediatrician has ruled there is no evidence of a persistent thymus. Because of the inconvenience to the mother, I have never deemed it necessary to hospitalize these patients over three to four days but keep them under constant supervision and return them to the hospital if the tension rises. The most common complication in my experience has been an eccentric pupil which is probably the result of the limbal puncture. I plan in the next case to make the puncture

within the cornea—1 to 2 mm. inside the limbus—and hope to avoid this complication.

In those patients 5 years of age or over who out of necessity have been delayed in their normal development, it occurs to me that a linear extraction within the cornea under general anesthesia and an irrigation of the anterior chamber after capsulotomy will hasten the restoration of sight and the delayed development of the child. It has been my experience that these patients seldom have a vision approaching normal, but in a large majority there results a vision sufficient for school study and an independence of adult life which is a great improvement on what nature gave them in the beginning.

Dr. Dan Brannin, Dallas: Dr. Hilgartner, with his extensive experience, has, I am sure, treated surgically more cases of congenital cataract than I have ever seen. I therefore feel some hesitancy in discussing his paper. There are, however, four points that I would like to stress:

1. I believe that the earlier these patients are operated on, the better the chance is for the development of useful vision. The macula is not fully developed until approximately six months after birth. The sooner it is trained by use, the better chance there is for vision.

2. Where there is a dense capsule remain, it seems to me that an iridotomy using DeWecker scissors produces less traumatism and less danger of uveitis than does removal of this capsule with forceps, regardless of how gentle the manipulation.

3. Dr. Hilgartner advises the immediate emptying of the anterior chamber in the event of a secondary glaucoma following the discission. Twice in my experience I have had suprarenin bitartrate control the rise in tension without further surgical interference. It would seem to me that it might be well to try this for twenty-four hours before resorting to additional surgery.

4. I would like to emphasize Dr. Hilgartner's point that the after care and follow-up on these cases should be continued until all the lens material is entirely absorbed and the eye is quiet. Failure to keep these eyes atropinized postoperatively for a sufficient period of time I am sure accounts for some poor results.

Dr. Ray K. Daily, Houston: Dr. Hilgartner has outlined very well indeed the management of congenital cataract. There is one point, however, that he has not brought out: a good organic surgical result may frequently be associated with disappointing vision. The reason for this lies in the congenitally poor function of many of these eyes, which is not corrected by the removal of the cataract. Technically surgery of congenital cataract is not difficult. But the degree of preoperative function which determines the final visual acuity in infants is very difficult to determine. The prognosis for good postoperative visual acuity depends to a great extent on whether the cataract at birth is so dense that all visual function is excluded or is partial, so that the impairment of vision does not interfere with the development of orientation. The prognosis for good visual acuity in partial or incomplete cataract is good; for dense cataracts, poor. Infants with dense cataracts develop an amblyopia exanopsia which may become irreversible; they should therefore be operated on early, long before the age when they get to the School for the Blind. These eyes with infantile cataract, however, stand surgery very poorly, and so the simpler the surgery the better the prognosis for a normal postoperative course. A frequent cause of poor postoperative vision in the dense cataract is the almost always existing nystagmus, which does not disappear even after an excellent operation. After the third year of life linear extraction is the operation of choice. In children with partial cataract, surgery might best be delayed until school age; they have enough vision to prevent the development of amblyopia exanopsia, and too early an operation, particularly a discission, carries with it the risk of amblyopia. After a discission, until the swollen lens masses are absorbed, the lens is more opaque than before the operation, and if the opacity persists for a long time the anopsia may give rise to an amblyopia, which is difficult to cure. In such cases it is probably best to postpone surgery until the child has grown beyond the amblyopiogenic age, which is 6 or 7. Since Dr. Hilgartner probably gets the children about that age his functional results should be better than that of the children operated on earlier in infancy. The better functional results, however, are caused not by the surgical management but by the physiologic factors which make the prognosis better for older children.

Dr. Everett L. Goar, Houston: Dr. Hilgartner does not distinguish between congenital cataracts in regard to etiology. The type that is apparently caused by intra-uterine inflammation, in which the iris is attached to the cataractous lens by dense adhesions, will not react favorably to any operation. Inflammation and fibrosis follow each operation and the result is either hydrophthalmos or atrophy. This condition is not to be confused with retralental fibroplasia which is no less hopeless.

Since adopting the Zeigler method of cutting anterior and posterior capsule with the needle knife, I have had no secondary glaucoma to follow discission of soft cataracts. This allows the swollen lens to expand backward as well as forward and in my opinion renders the operation safer and prevents repeated discissions.

TUBERCULOSIS COMMITTEES MEET JOINTLY

The Tuberculosis Committee of the State Medical Association and the Executive Committee of the Texas Tuberculosis Association held a joint meeting in Austin, December 15, following a meeting of the board of directors of the Tuberculosis Association. Dr. C. M. Hendricks, El Paso, chairman of the State Medical Association committee, presided.

Dr. Hendricks suggested that the two committees meet regularly on the dates of the quarterly board meetings of the Texas Tuberculosis Association. It was pointed out that with one exception, all members of the State Medical Association committee are also members of the board of the State Tuberculosis Association and that joint meetings would give the members of each group a clear picture of what is going on in tuberculosis control. Dr. Hendricks suggested additional coöperation by means of mutual exchange of data pertinent to statewide tuberculosis control.

Following a presentation of an outline of the objectives of the State Medical Association Tuberculosis Committee, current instruction on tuberculosis given in medical schools was discussed, the consensus being that the program should be expanded. Conditions at the Kerrville Sanatorium were then considered, and it was agreed that a joint committee, appointed at the meeting, would visit the Kerrville Sanatorium and later the State Sanatorium to report and make recommendations to the State Board of Control prior to the convening of the Fiftieth Legislature. A bill providing for establishment of two district sanatoriums, to be introduced in the Legislature, was discussed in detail.

Dr. Howard E. Smith, director of the Tuberculosis Control Division, State Health Department, gave a resume of the biennial report which he had submitted with the Health Department report to the Board of Control.

MEMBERS OF THE FIFTIETH TEXAS LEGISLATURE

The names of Senators and Representatives in the Fiftieth Legislature of Texas are listed below by districts for the convenience of those who wish to contact them in connection with the current legislative program of the State Medical Association and of other groups interested in improving health conditions in the state.

SENATORS BY DISTRICTS

1.	Howard Carney	Atlanta
2.	Wardlow Lane	Center
3.	Ben Ramsey	San Augustine
4.	W. R. Cousins, Jr.	Beaumont
5.	Roger A. Knight	Madisonville
6.	James E. Taylor	Kerens
7.	T. C. Chadick	Quitman
8.	A. M. Aikin, Jr.	Paris
9.	Charles R. Jones	Bonham
10.	G. C. Morris	Greenville
11.	Fred Red Harris	Dallas
12.	A. B. Crawford	Granbury
13.	Kyle Vick	Waco
14.	J. Alton York	Bryan
15.	Gus Strauss	Hallettsville
16.	W. Lacy Stewart	Houston
17.	Jimmy Phillips	Angleton
18.	Fred Mauritz	Ganado
19.	R. A. Weinert	Seguin
20.	James A. Stanford	Austin
21.	Buster Brown	Temple
22.	R. L. Proffer	Justin
23.	George Moffett	Chillicothe
24.	Pat Bullock	Colorado City
25.	Dorsey B. Hardeman	San Angelo
26.	Walter Tynan	San Antonio
27.	Rogers Kelley	Edinburg
28.	Keith Kelly	Fort Worth
29.	H. L. Winfield	Fort Stockton
30.	Sterling J. Parrish	Lubbock
31.	Grady Hazlewood	Amarillo

REPRESENTATIVES BY DISTRICTS

1.	Joe Thomas Kennington	Texarkana
2.	W. A. Barber	Linden
3f.	J. P. Fant	Jefferson
4.	Surry Turner	Gilmer
5.	Isom P. (Bill) Hydrick, Jr.	Marshall
6f.	Cecil Storey	Longview
7.	Thomas Harris Sharp	Beckville
8.	Joe B. Fleming	Henderson
9.	Jewell Helpinstill	Nacogdoches
10.	C. G. Lightfoot	Timpson
11.	Paul S. Wilson	Geneva
12.	Ottis E. Lock	Lufkin
13.	Edward P. Hughes, Jr.	Newton
14.	David Read	Silsbee
15f.	Miller B. Walker	Beaumont
16.	Jack B. Brooks	Beaumont
	Otis Lee	Port Arthur
17f.	Louie D. Godard	Texas City
18.	Donald M. Markle	Galveston
19.	Charles A. Murphy, Jr.	Houston
	Carlton Moore, Sr.	Houston
	Searcy Bracewell	Houston
	J. M. Heflin	Houston
	William A. (Bill) Miller, Jr.	Houston
20.	J. F. Ward	Rosenberg
21.	Carlton Crawford	Palacios
22.	Lloyd M. Guffey	Wharton
23.	Marvin D. Fertsch	Hallettsville
24.	J. A. Luedemann	Brenham
25.	C. S. McLellan	Eagle Lake
26.	W. T. (Bill) Moore	Bryan
27f.	Mrs. Neveille H. Colson	Navasota
28.	Lesta Shackelford	Livingston
29.	M. B. Etheredge, Jr.	Huntsville
30.	J. B. Sallas	Crockett
31.	Pat Wiseman	Jacksonville
32.	Bill Wood	Tyler
33f.	F. G. Swanson	Tyler
34.	Miss Elizabeth Suiter	Winnsboro
35.	Alford H. Flanagan	Talco
36.	Grady Moore	Clarksville
37.	George W. Watson	Paris
38f.	John Ford	Paris
39.	E. O. Chapman	Sulphur Springs
40.	Fred J. Jones	Lone Oak
41.	Ray Kirpatrick	Trenton
42f.	J. O. Berry	Commerce
43.	Davis Clifton	McKinney
44.	James T. (Jim) Sparks	Sherman
	Sidney McClain	Sherman
45f.	Roger Q. Evans	Denison
46.	C. C. Gardner	Gainesville
47.	Wayne W. Waggonseller	Fruitland
48.	L. C. Slimp, Jr.	Decatur
49.	Robert Hal Jackson	Denton
50.	John L. Crosthwait	Dallas
	W. O. Reed	Dallas
	Sam Hanna	Dallas
	George Parkhouse	Dallas
	Dallas A. Blankenship	Dallas
51f.	Preston Mangum	Dallas
52.	Phillip L. Willis	Kaufman
53.	M. K. Thomas	Wills Point
54.	James C. Spencer	Athens
55.	A. J. (Jack) Overton, Jr.	Palestine
56.	Gus M. Lanier	Marquez
57.	Elmer McVey	Teague
58.	George O. Nokes, Jr.	Corsicana
59.	Andy M. James	Hillsboro
60f.	Jerry T. Stockard	Frost
61.	A. R. (Robin) Henderson	Groesbeck
62.	Frank C. Oltorf, Jr.	Marlin
63.	Herman Yezak	Bremond
64.	A. N. Green	Cameron
65f.	Henry G. Lehman	Giddings
66.	R. B. Spacek	Fayetteville
67.	Durwood Manford	Smiley
68.	John J. Bell	Cuero
69.	William S. Fly	Victoria
70.	H. L. Atkinson	Beeville
71.	O. E. Cannon	Corpus Christi
72.	Augustine Celaya	Brownsville
73.	Joe M. Kilgore	McAllen
74.	Sam G. Reams	Falfurrias
75.	Abraham Kazen, Jr.	Laredo
76.	Donald Peters	Cotulla
77.	Britton T. Edwards, Jr.	LaPryor
78.	W. A. (Cap) Williamson	San Antonio
	Eugene C. Williams	San Antonio
	Jack F. Ridgeway	San Antonio
	Marshall O. Bell	San Antonio
	O. E. Latimer	San Antonio
79.	L. L. Holstein	Pandora
80.	H. A. Heideke	Seguin
81.	William George Richards	Lockhart
	Max C. Smith	San Marcos
82.	J. Pearce Johnson	Austin
	Obie Jones	Austin
83.	Frank Svadlenak	Thrall
84f.	William R. Stump	Georgetown
85.	Tom Martin	Fredricksburg
86.	C. H. Gilmer	Rock Springs
87.	Charles B. Moore III	Del Rio
88.	George Elliott	Odessa
89.	S. J. Isaacks	El Paso
	William S. Jameson	El Paso
90f.	Woodrow W. Bean	El Paso
91.	R. E. Blount	Big Spring
92.	W. H. Rampy	Winters
93.	Reuben E. Senterfitt	San Saba
94.	Sid Gregory, Jr.	Gatesville
95.	Lamar Zivley	Temple
96f.	Sam C. Sellers	Waco
97.	Gordon Davis	Waco
	J. K. Aynesworth	Waco
98f.	Albert M. Jones	Valley Mills
99.	D. D. Gathings	Cleburne
100.	Mrs. Rae Files Still	Waxahachie
	Don A. Lewis	Midlothian
101.	Joe Pyle	Fort Worth
	W. H. (Bill) Abington	Fort Worth
	Doyle Willis	Fort Worth
	John L. (Red) Wallace	Fort Worth
102f.	Warren C. Cowen	Fort Worth
103.	Jim Wright	Weatherford
104.	W. E. Heatly	DeLeon
105.	J. W. (Bill) Shannon	Stephenville
106.	T. M. Collie	Eastland
107f.	L. R. Pearson	Ranger
108.	Jack Cox	Breckenridge
109.	N. F. (Dick) Smith	Jacksboro
110.	Jimmy P. Horany	Archer City
111.	C. M. McFarland	Wichita Falls
	Vernon McDaniel	Wichita Falls
112f.	Leslie King	Harrold
113.	Charles M. Conner	Haskell
114.	Claude Calloway	Crowell
115.	William B. Teague	Anson
116.	W. K. (Bill) Tippen	Abilene
117.	Harley Sadler	Sweetwater
118.	Sterling Williams	Snyder
119.	Preston E. Smith	Lubbock
120.	I. B. Holt	Olton
121.	Sheffy Mahan	Childress
122.	R. L. Templeton	Wellington
123.	J. Blake Timmons	Amarillo
124.	William J. (Bill) Craig	Miami
125.	Charles L. South	Coleman
126f.	Joe W. Gandy	Winnsboro
127.	Harry Whitworth	Smithville

MISCELLANEOUS

COMING MEETINGS AND CLINICS

State Medical Association of Texas, Dallas, May 5-8, 1947. Dr. C. C. Cody, Jr., Houston, President; Dr. Holman Taylor, 1404 W. El Paso St., Fort Worth 3, Secretary.

American Medical Association, Atlantic City, N. J., June 9-13, 1947. Dr. Harrison H. Shoulders, Nashville, Tenn., President; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secretary.

Southern Medical Association, November, 1947. Dr. E. L. Henderson, Louisville, Ky., President; C. P. Loranz, Empire Building, Birmingham, Ala., Secretary-Manager.

Southwest Allergy Forum, Shreveport, La., March 31-April 1, 1947. Dr. W. H. Browning, Shreveport, La., President; Dr. Sim Hulsey, Medical Arts Bldg., Fort Worth, Secretary.

Texas Association of Medical Anesthetists, Dallas, May 5, 1947. Dr. Claudia Potter, Temple, President; Dr. Russell Bonham, Box 6237, Houston, Secretary.

Texas Association of Obstetricians and Gynecologists, Fort Worth, November, 1947. Dr. J. E. Kanatser, Wichita Falls, President; Dr. Julius McIver, 714 Medical Arts Building, Dallas, Secretary.

Texas Chapter, American College of Chest Physicians, May 5, 1947. Dr. R. G. McCorkle, San Antonio, President; Dr. Elliott Mendenhall, 1217 Medical Arts Bldg., Dallas, Secretary.

Texas Club of Internists. Dr. Alvis E. Greer, Houston, President; Dr. Julian C. Barton, 414 Navarro St., San Antonio, Secretary.

Texas Hospital Association, Houston, March 27-29, 1947. Tol Terrell, Harris Memorial Methodist Hospital, Fort Worth, President; Mrs. Ruth Barnhart, 2210 Main St., Dallas, Secretary.

Texas Neuropsychiatric Association, Dallas, May 5, 1947. Dr. Fred T. Rogers, Dallas, President; Dr. David Wade, 604 Capital National Bank Bldg., Austin, Secretary.

Texas Orthopedic Society. Dr. E. A. Cayo, San Antonio, President; Dr. Edward Smith, 1215 Walker Ave., Houston, Secretary.

Texas Pediatric Society, Houston, October, 1947. Dr. J. R. Lemmon, Amarillo, President; Dr. John E. Ashby, 3610 Fairmount, Dallas, Secretary.

Texas Public Health Association, Dallas, February 23-26, 1947. Dr. L. P. Walter, Austin, President; Mr. Earle W. Sudderth, Dallas County Health Department, Court House, Dallas, Secretary.

Texas Radiological Society. Dr. C. A. Stevenson, Temple, President; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secretary.

Texas Railway and Traumatic Surgical Association, May 5, 1947, Dr. F. L. Snyder, Fort Worth, President; Dr. Ross Trigg, First National Bank Bldg., Fort Worth, Secretary.

Texas Society for Mental Hygiene, San Antonio, April 10-12, 1947. Dr. Jack R. Ewalt, University of Texas Medical Branch, Galveston, President; Mrs. Elizabeth F. Gardner, 1617 Watchhill Road, Austin 21, Executive Secretary.

Texas Society of Gastro-Enterologists and Proctologists. Dallas, May 5, 1947. Dr. Tom E. Smith, Dallas, President; Dr. D. L. Curb, 704 Dallas Ave., Houston, Secretary.

Texas Society of Ophthalmology and Otolaryngology, Houston, December, 1947. Dr. W. E. Vandevere, El Paso, President; Dr. E. D. Dumas, 425 Medical Arts Bldg., San Antonio, Secretary.

Texas Society of Pathologists, Business Session, Dallas, May 7, 1947; Annual Session, Galveston, January 25, 1948. Dr. D. A. Todd, San Antonio, President; Dr. C. T. Ashworth, Southwestern Medical College, Dallas, Secretary.

Texas State Heart Association, Dallas, May 5, 1947. Dr. Robert M. Barton, Dallas, President; Dr. M. B. Whitten, Medical Arts Bldg., Dallas, Secretary.

Texas State Urological Society, Dallas, November or December, 1947. Dr. Jo C. Alexander, Dallas, President; Dr. Hub Isaacks, Medical Arts Bldg., Fort Worth, Secretary.

Texas Surgical Society, Dallas, April, 1947. Dr. Walter Stuck, San Antonio, President; Dr. Truman G. Blocker, University of Texas Medical Branch, Galveston, Secretary.

Texas Tuberculosis Association, Dallas, September 15-16, 1947. F. K. Dougharty, Liberty, President; Miss Pansy Nichols, 700 Brazos, Austin, Executive Secretary.

Third, Panhandle, District Medical Society, Amarillo, April 8-9, 1947. Dr. W. A. Carroll, Claude, President; Dr. George Powers, Fisk Bldg., Amarillo, Secretary.

Fourth District Medical Society, Coleman, 1947. Dr. Glenn H. Ricks, Brady, President; Dr. J. C. Young, Coleman, Secretary.

Seventh, Austin. District Society, February, 1947. Dr. Robert B. Morrison, Austin, President; Dr. M. I. Brown, Capital National Bank Bldg., Austin, Secretary.

Eighth, Ninth and Tenth Districts Medical Society, Orange, April, 1947. Dr. Walter F. Hasskarl, Brenham, President; Dr. George W. Waldron, Medical Arts Bldg., Houston, Secretary.

Eleventh District Society. Dr. L. L. Travis, Jacksonville, President; Dr. C. B. Young, 929 S. Confederate, Tyler, Secretary.

Twelfth, Central Texas, District Society, Marlin, July 8, 1947. Dr. W. Howard Wells, Waco, President; Dr. H. F. Connally, Jr., Amicable Bldg., Waco., Secretary.

Thirteenth, Northwest District Society, Abilene, April 22, 1947. Dr. Frank Hodges, Abilene, President; Dr. Robert C. Stokes, 501 First National Bank Bldg., Fort Worth, Secretary.

Fourteenth District Society. Dr. C. B. Thayer, Gainesville, President; Dr. James Jeter, Ennis, Secretary.

Fifteenth, Northeast Texas, District Society. Dr. Joe Roberts, Longview, President; Dr. S. W. Tenney, Marshall, Secretary.

CLINICS

Dallas Southern Clinical Conference, Dallas, March 17-20, 1947. Miss Thelma J. Webb, 1133 Medical Arts Bldg., Dallas 1, Executive Secretary

New Orleans Graduate Medical Assembly, New Orleans, February 24-27, 1947. Dr. Max M. Green, Room 105, 1430 Tulane Ave., New Orleans 13, Secretary.

HOSPITALS NEEDING INTERNS AND RESIDENTS

Methodist Hospital, Dallas. Capacity 206 beds. C. B. Fielder, Superintendent (interns desired, July, 1947).

El Paso City County Hospital, El Paso. Capacity 192 beds. George W. Cook, Col., U. S. A., Ret., Superintendent (3 interns for one year term, graduates of class A medical school only).

All Saints Episcopal Hospital, Fort Worth. Capacity, 110 beds. Approved for graduate residency. Eva M. Wallace, R. N., Superintendent (1 resident immediately; 2 by July 1).

NEUROPSYCHIATRY RESIDENCY OFFERED

Southwestern Medical Foundation in coöperation with the Veterans Administration is offering a three-year residency in neuropsychiatry. Two years of this are divided into eight-month rotation periods between the Dallas area and the Veterans Administration hospitals at McKinney and Waco. The third year is elective, and investigative work is included. Approximately one-half of the required time covers psychosomatic medicine and mental hygiene work, including child guidance. The other half is inpatient psychiatry. A Dean's Committee composed of Dr. Guy Witt, Dr. P. C. Talkington, and Dr. Don Morris, secretary, is supervising the program. Further information may be secured from the Secretary, Dean's subcommittee for Neuropsychiatry, Southwestern Medical College, 2211 Oak Lawn Avenue, Dallas 4.

AMERICAN COLLEGE OF SURGEONS TO HOLD SECTIONAL MEETING IN TEXAS

Southwestern and southern fellows of the American College of Surgeons will convene at the Hotel Texas, Fort Worth, on March 20 and 21 for a sectional meeting. The medical profession at large, medical students, and hospital personnel have been invited to participate in the meeting, for which no registration fee will be charged.

Tentative plans call for a medical program and a hospital program. Both will include panel discussions, round table luncheon conferences, and motion pictures. A dinner and reception will be held the evening of March 20. Subjects probably to be included on the medical program concern carcinoma of the stomach and the colon; advances in anesthesia, including the use of curare; surgery of the kidney; surgery of the thyroid in relation to the use of thiouracil; intestinal obstruction; fractures of the hip, forearm, and elbow joint; the use of antibiotics in surgical practice; surgery of malignant growths in the neck; surgical measures and the use of anticoagulants in the prevention of pulmonary embolism; and postoperative care.

Dr. Curtice Rosser, Dallas, is chairman of the Texas executive committee of the College, and Dr.

T. H. Thomason, Fort Worth, is chairman of the local arrangements committee. Other members of the committee include Drs. May Owen, Frank W. Halpin, Louis Levy, Joe R. Wise, Frank Schoonover. George Enloe, J. Eschenbrenner, and Jerrell Bennett, and Tol Terrell, president of the Texas Hospital Association.

DALLAS HEALTH MUSEUM EXPANDS

Plans are being made by the Dallas Health Museum to employ a staff of full-time workers trained in the field of public health and to establish an extension program which will make available many of the museum's services to school, club, or business personnel without the necessity of a visit to the museum itself. These plans for expansion have been announced by Edward W. Brady, president of the Dallas Medical Services Society, one of the sponsors of the health museum. A drive for funds to operate such a program is being made during February and March.

The museum, established last October by the Dallas Academy of Medicine, is increasing its emphasis on demonstrations of modern medicine and health methods, public forums, and classes in hygiene. Motion pictures on a variety of health topics are already being shown. It is anticipated that motion pictures and other movable displays will be made available to larger audiences through the proposed extension service. At present health displays, motion pictures, and lectures are offered free to visitors at the museum in Fair Park.

TEXAS SOCIETY OF OPHTHALMOLOGY AND OTO-LARYNGOLOGY

One hundred six members and guests of the Texas Society of Ophthalmology and Oto-Laryngology were present at the twenty-first annual meeting in Dallas, December 6-7. They selected Houston as the next meeting place, with the date to be sometime in December, 1947.

New officers elected include Drs. W. E. Vandevere, El Paso, president; Sam N. Key, Sr., Austin, first vice-president; Lester H. Quinn, Dallas, second vice-president; E. D. Dumas, San Antonio, secretary; J. Charles Dickson, Houston, treasurer; and M. K. McCullough and John G. McLaurin, Dallas, and C. H. Brooks, Waco, councilors.

The scientific program was as follows:

December 6

Observations on the Effects of Diisopropyl Fluorophosphate—Dr. John L. Matthews, San Antonio.
Discussion: Dr. Dan Brannin, Dallas, and Dr. W. E. Muldoon, San Antonio.
Acute Mastoiditis Masked by Penicillin Therapy—Dr. John H. Barrett, Houston.
Discussion: Dr. Herbert H. Harris, Houston, and Dr. James P. Aderhold, San Antonio.
Surgical Treatment of Cataract—Dr. C. S. O'Brien, University of Iowa, Iowa City.
Luncheon—Dr. Tom Barr, Dallas, presiding.
Honor Guests: Dr. William A. Wagner, Dr. C. S. O'Brien, and Dr. S. N. Key, Jr.
Cytologic Lavage of Sinuses—Dr. William A. Wagner, Tulane University, New Orleans.
Diagnosis and Treatment of Convergent Strabismus—Dr. S. N. Key, Jr., Austin (formerly of University of Iowa).
Surgical Treatment of Cataract (continued)—Dr. C. S. O'Brien.

December 7

Stenosis of the Esophagus—Dr. George S. McReynolds, Galveston.
Discussion: Dr. Oliver W. Suehs, Austin, and Dr. August J. Streit, Amarillo.
Retinochoroiditis Juxta Papillaris—Dr. William J. Snow, Houston.
Discussion: Dr. F. J. Slataper, Houston, and Dr. H. L. Hilgartner, Jr., Austin.
Otosclerosis—Dr. William A. Wagner.
Diagnosis and Treatment of Convergent Strabismus (continued)—Dr. S. N. Key, Jr.

Registrants and their wives attended a cocktail party and formal banquet the evening of December 6.

Dr. Edward H. Cary was general chairman of local committees, and Mrs. Hugh L. McLaurin was chairman of a luncheon for visiting women.

UNIVERSITY OF TEXAS POSTGRADUATE COURSE IN PHYSICAL MEDICINE

Additional details regarding the March 3-7 postgraduate course in physical medicine and rehabilitation to be offered by the University of Texas Medical Branch, Galveston, have been released. The program will include symposia on arthritis and on poliomyelitis, a discussion of the use of physical medicine in general practice and in specific medical specialties, instruction in the therapeutic use of physical medicine aids for specific conditions, and a discussion of rehabilitation measures involving physical medicine. Demonstrations and motion pictures will be used in addition to lectures, and physical therapy equipment will be on display. Instructors will advise those interested in establishing physical therapy and occupational therapy programs in their own cities. Seventeen outstanding guest speakers have been invited to participate in the course, and fourteen members of the University staff will assist.

Basil O'Connor, president of the National Foundation for Infantile Paralysis, and Dr. George M. Piersol, professor of medicine, Graduate School of Medicine, and professor of clinical medicine, University of Pennsylvania Medical School, will speak at a banquet the evening of March 6.

Physicians and qualified physical therapy technicians planning to attend the session should register in advance with Dr. Truman G. Blocker, director of postgraduate training at the University. A fee of $25 will be charged for the entire course, with an additional $2 fee for those desiring certification of attendance. A fee of $5 per day will be charged those who wish to attend only part of the time.

TEXAS HOSPITAL ASSOCIATION

The Texas Hospital Association has extended an invitation to physicians in the state to attend the eighteenth annual convention of the Association at the Rice Hotel, Houston, March 27, 28, and 29.

The program will cover health subjects of current nationwide and local interest, and prominent national and state speakers will contribute toward making it a success. The national retirement program for hospital employees, Texas Hospital Survey Report, state hospital legislative program, prepaid hospital and medical care in Texas, Veterans Administration program, program of the State Medical Association, and public relations will be the outstanding topics. Panel programs covering current problems in all hospital departments also are scheduled.

Dr. L. L. D. Tuttle, Houston, who has been appointed delegate from the State Medical Association to the Texas Hospital Association by the Medical Association President upon the request of the Hospital Association president that a representative be named, will appear on the program.

Four state associations of allied health groups will hold their annual meetings in the Rice Hotel at the same time: hospital women's auxiliaries, occupational therapists, medical record librarians, and nurse anesthetists.

Texas physicians have always had a cordial welcome at the meetings of the Texas Hospital Association, but with the continually increasing overlapping of activities in all the health fields, Hospital Association officials are particularly eager to have physicians at the Houston meeting this year.

U. S. PUBLIC HEALTH NURSE EXAMS

The U. S. Public Health Service has announced a schedule of examinations for the appointment of nurses to the first three grades of its regular commissioned corps. Positions are open in Marine hospitals, public health nursing, and certain special projects of the Public Health Service. Oral examinations will be held at the Marine Hospital, Forty-Fifth Street and Avenue N, Galveston, on March 18, with written examinations scheduled in April. Additional information may be secured from the Marine Hospital.

ERROR IN CIBA SLIDE RULE

Because of a manufacturer's error in the placement of a decimal point, the medical "Slyd-Rul" enclosed in the December issue of *Ciba Symposia*, widely distributed to physicians by Ciba Pharmaceutical Products, Inc., is incorrect. The pharmaceutical concern has requested that recipients of the slide rule be informed that conversion from 0.4 grain to gram should read 0.025 gram, instead of 0.25. A temporary paper table is being mailed to replace the original celluloid table, and a new celluloid table will be sent as soon as possible.

LIBRARY NOTES

PACKAGE SERVICE

The package library consists of collections of reprints and other periodical material on various subjects, prepared for lending to members of the Association. Requests for packages should be addressed "Library, State Medical Association of Texas, 1404 W. El Paso Street, Fort Worth 3, Texas." Twenty-five cents in stamps should be enclosed with the request to cover postage and part of the expense of collecting the material. Only one package may be borrowed at a time, and packages are allowed to remain in the hands of the borrower for 14 days.

Packages were mailed from the Library of the State Medical Association to the following during January:

Dr. C. Curtis Allen, Wichita Falls—*Forceps* (6 articles).

Dr. Raymond H. Tull, Abilene—(2 journals).

Dr. Frank W. Kelley, Pampa—*Paravertebral Block* (14 articles).

Dr. William M. Blair, Wharton—(3 journals).

Dr. George Tulloch, Okmulgee, Okla.—(1 journal).

Dr. J. H. Grammer, Fort Worth—*Abscess, subphrenic* (14 articles).

Dr. Charles Mims, Mission—*Labor* (14 articles); *Anesthesia, nitrous oxide* (17 articles); *Anesthesia, barbital derivatives* (8 articles); *Hemorrhoids, therapy* (17 articles).

Dr. Charles B. Reed, Clarksville—*Arthritis, therapy* (20 articles).

Dr. R. W. Loveless, Bastrop—*Asthma, therapy* (7 articles).

Dr. S. N. Key, Jr., Austin—*Undulant Fever, diagnosis* (20 articles).

Dr. Maxwell Thomas, Dallas—*Eyes, cysts* (5 articles).

Dr. C. C. Pate, Paducah—*Erythroblastosis, fetal* (23 articles).

Shannon West Texas Memorial Hospital, San Angelo—*Thrombophlebitis* (13 articles); *Sympathectomy* (11 articles); *Nerves, vagus* (8 articles).

Dr. James W. Williams, Mineola—(9 journals).

Dr. Jesson L. Stowe, El Paso—*Blood, groups* (20 articles).

Southwestern Medical Library, Dallas—(1 journal); (1 journal).

Scott and White Clinic Library, Temple—(1 journal); (4 journals).

Dr. Frank B. Duncan, Amarillo—*Deafness* (2 articles).

Dr. B. B. Friedman, Corpus Christi—(1 book).

Dr. W. A. Chernosky, Temple—(2 journals).

Dr. J. P. Gibson, Abilene—*Oxyuriasis* (7 articles).

Dr. Ray G. Boster, Sanatorium—(21 articles).

Dr. R. R. Wills, Hereford—*Anemia, aplastic* (22 articles).

Dr. Charles A. Shoultz, Bay City—*Tuberculosis, therapy* (7 articles).

Dr. F. O. McGehee, Houston—(1 journal).

Drs. Lamm and Lamm, La Feria—*Urethra roentgenography* (3 articles).

Dr. N. A. Elder, Nixon—*Measles, immunity* (11 articles).

Dr. Edward T. Kealey, Johnson City—*Prostigmine* (8 articles).

Dr. Frank H. Kidd, Jr., Dallas—*Blood, proteins* (17 articles); *Diet and Dietetics* (18 articles); *Nutrition* (9 articles).

Dr. J. B. Bauknight, Ganado—*Stilbamidine* (2 journals).

Dr. M. S. Ragland, Gilmer—(1 journal).

Dr. C. R. Finnegan, Dallas—*Uterus, hemorrhage* (16 articles).

Dr. B. M. Puckett, Amarillo—*Medicine, progress* (17 articles).

Dr. James P. Gill, San Antonio—*Glasses, contact* (16 articles).

Dr. James N. White, San Angelo—*Carotid Sinus* (13 articles).

Dr. David McCullough, Kerrville—(2 journals).

Dr. H. L. Wilder, Pampa—*Radioactivity* (27 articles).

Dr. J. H. Simons, Bay City—(1 journal).

Dr. J. P. McAnulty, San Angelo—*Mediastinum, inflammation* (1 article).

Dr. H. A. Scott, Austin—*Kleptomania* (3 articles).

Dr. Charles R. Hartsook, Wichita Falls—*Medicine, progress* (7 articles).

Packages on compulsory sickness insurance to superintendents, debate coaches, and students in Texas High Schools, 12.

ACCESSIONS

New York, The John Day Company—Carlson: Born That Way.

New York, Paul B. Hoeber—Mengert: Postgraduate Obstetrics.

Torbett: The Doctor's Scrapbook, privately printed.

Philadelphia, W. B. Saunders Company—Hyman: An Intergrated Practice of Medicine, four volumes and index; Cooke: Allergy in Theory and Practice; Novak: Gynecological and Obstetrical Pathology.

SUMMARY

REPRINTS RECEIVED, 682.	LOCAL USERS, 53.
JOURNALS RECEIVED, 196.	BORROWERS BY MAIL, 51.
ITEMS CONSULTED, 239.	PACKAGES MAILED, 60.
ITEMS TAKEN OUT, 299.	ITEMS MAILED, 564.

TOTAL ITEMS CONSULTED AND MAILED, 1,102.

MOTION PICTURE FILM LIBRARY

Motion picture films on medical subjects, 16 mm., both silent and sound, some in color, and suitable for either medical or lay audiences, are available for loan to county medical societies, hospital staffs, or individual physicians, on request. Borrowers will be required to pay only the cost of shipment of the films, by express, with insurance, and for any damage to films while in the hands of the borrower.

Requests for films should be addressed to "Motion Picture Film Library, State Medical Association of Texas, 1404 West El Paso Street, Fort Worth 3, Texas." A list of available films, with descriptions, will be furnished on request.

The following motion picture films were loaned

by the Film Library of the State Medical Association of Texas during January:

Amputation of the Lower Extremities (Available through the courtesy of the Medical Department of the U. S. Army)—Medical and intern staff of the Santa Rosa Hospital, San Antonio.

Another to Conquer (Available through the courtesy of the Texas Tuberculosis Association)—Lufkin High Schools, Lufkin.

Appendicitis in Childhood (Available through the courtesy of Mead Johnson & Company)—Nacogdoches County Medical Society, Nacogdoches.

Chest X-Ray Routine Admissions (Available through the courtesy of the Texas Tuberculosis Association)—Tuberculosis nursing consultants from 10 southern states, Dallas.

Chest X-Ray Techniques (Available through the courtesy of the Texas Tuberculosis Association)—Tuberculosis nursing consultants from 10 southern states, Dallas.

Choose to Live (Available through the courtesy of the U. S. Public Health Service and the American Society for the Control of Cancer)—Price Hospital Staff and the Delphian Club, Lamesa.

Convalescent Care and Rehabilitation of Patients with Spinal Injury (Available through the courtesy of the Medical Department of the U. S. Army)—Victoria Hospital Staff, Victoria.

D. D. T., the Story of (Available through the courtesy of the British Information Services)—Brownwood Rotary Club and the Kiwanis Club, Brownwood.

Evacuation of the Wounded (Available through the courtesy of the Medical Department of the U. S. Army)—Six-County Medical Auxiliary, Big Spring.

Forty Billion Enemies (Available through the courtesy of Westinghouse Electric and Manufacturing Co.)—Kiwanis Club, Brownwood, and the Public Health Department, Fort Worth.

From Moo to You (Available through the courtesy of the Borden Company)—Public Health Department, Fort Worth.

Golden Glory (Available through the courtesy of Standard Brands, Inc.)—Kiwanis Club, Brownwood, and the Public Health Department, Fort Worth.

Mastoidectomy (Available through the courtesy of Dr. Louis Daily, Houston)—Harris College of Nursing, Fort Worth.

Medical Service in the Invasion of Normandy (Available through the courtesy of the Medical Department of the U. S. Army)—Six-County Medical Auxiliary, and the Malone-Hogan Hospital Staff, Big Spring.

Medical Service in the Jungle (Available through the courtesy of the Medical Department of the U. S. Army)—Six-County Medical Auxiliary, Big Spring.

Plaster Casts (Available through the courtesy of the Medical Department of the U. S. Army)—Crystal Clinic and Hospital, Crystal City.

Premature Infant, the Care of (Available through the courtesy of Mead Johnson and Company)—Victoria Hospital Staff, Victoria.

Normal Delivery (Available through the courtesy of Mead Johnson and Company)—Harris College of Nursing, Fort Worth.

TB, This Is (Available through the courtesy of the Texas Tuberculosis Association)—Lufkin High Schools, Lufkin.

Underwater Therapy, Victoria Hospital Staff, Victoria.

Accent on Use (Available through the courtesy of the National Foundation for Infantile Paralysis)—Kiwanis Club, Brownwood.

Anesthesia, Intravenous (Available through the courtesy of Abbott Laboratories)—Gray-Wheeler Counties Medical Society, Pampa.

NEW MOTION PICTURES FOR THE FILM LIBRARY

The Motion Picture Film Library of the State Medical Association has received the following films from Mead Johnson & Company, Evansville, Ind., for relending:

Cholecystectomy. 16 mm., silent, showing time, 28 minutes. This picture shows the operative procedures in this type of surgery, including several anomalous conditions. It was made by Dr. Dennis R. W. Crile, Augustana Hospital, Chicago.

Hysterectomy. 16 mm., silent, showing time, 19 minutes. This film was made by Dr. Dennis R. W. Crile, Augustana Hospital, Chicago. It shows a hysterectomy, including several different pathologic conditions and anomalies.

LIBRARY NEEDS

The journals listed below are needed by the Library of the State Medical Association to complete volumes for binding. Any of these numbers will be acceptable either as a gift or for purchase. It is preferable that the Library, 1404 West El Paso Street, Fort Worth 3, be notified regarding items available, and the prices of such items, if any, before shipment is made. The numbers needed follow:

American Heart Journal, Vol. 10, No. 2. (Dec.) 1934.

American Journal of Digestive Diseases, Vol. 2, No. 2 (April) 1935.

Archives of Surgery, Vol. 26, No. 6 (June) 1933.

Endocrinology, Vol 12, No. 4 (July-Aug.) 1928.

Industrial Hygiene, Vol. 17, No. 6 (Nov.) 1935.

Journal of the Michigan State Medical Society, Vol. 32, No. 8 (Aug.) 1933.

Journal of the Oklahoma State Medical Association, Vol. 26, No. 4 (April) 1933.

Southern Surgeon, Vol. 4, No. 3 (June) 1935.

BOOK REVIEWS

[1]**The Surgical Technic of Abdominal Operations.** By Julius Spivack, M. D., LL. D., Associate Professor of Surgery, University of Illinois College of Medicine. Cloth, 710 pages. 682 illustrations on 362 figures, mostly original. Fourth edition. Price, $10.00. Springfield, Illinois, Charles C. Thomas, Publisher, 1946.

This is an interesting book and well worth having. The technique of surgical operations is presented in a definite, detailed, and orderly fashion.

The author gives much of the historical background of each operation briefly yet adequately. The surgical anatomy is well described, and pertinent points concerning various possible surgical errors and precautions are mentioned. The illustrations are numerous and, on the whole, very good. A few are too diagrammatic, but this fault is found in most similar works.

The book should be very useful to refresh one's memory where various names are attached by usage to certain procedures. The author gives a brief but complete description of all the accepted variations of any given surgical procedure under the different

[1]Reviewed by J. Peyton Barnes, M. D., Houston, Texas.

names, and this in itself adds a great deal to the book.

The section on stomach surgery, surgery of the gallbladder and biliary ducts, and surgery of the pancreas is very good and up to date.

This book is recommended for the surgical resident and for the experienced practitioner, as each will get value from its perusal.

NEWS

Contributions to this department will be appreciated. News should be of general medical interest, such as public health activities, new hospitals, personal items of more than local value, etc. News for a particular number of the JOURNAL should be in the hands of the Editor not later than the fifteenth of the preceding month.

The American College of Surgeons has released a list of Texans who were received into fellowship at the convocation held December 20 in Cleveland, during the clinical congress of the college. The new fellows are Drs. Prentice Crumpler, Jr., Temple; Albert P. D'Errico, Dallas; Charles H. Dittman, San Antonio; Norman Duren, Beaumont; J. Wade Harris, Houston; Ben F. Harrison, Dallas; Ridings E. Lee, Dallas; Henrie E. Mast, Lubbock; Edward D. McKay, Temple; Maurice J. Meynier, Jr., Houston; Robert C. L. Robertson, Houston; Joseph P. Salerno, Houston; Lawrence M. Shefts, San Antonio; Edward T. Smith, Houston; Maurice P. Spearman, El Paso; Robert Mayo Tenery, Waxahachie; Joseph R. Theriot, Jr., Houston; Leroy Trice, Palestine; and Margaret Watkins, Dallas.

The Association of American Physicians and Surgeons is sponsoring its first annual essay contest for junior and senior high school students on the subject, "Why the Private Practice of Medicine Furnishes This County with the Finest Medical Care." Prizes of $1,000 for the best essay, $500 for the second best, and $100 for the third best are being offered for essays of 1,500 words or less by junior or senior high school students who are not the children of physicians. Dr. Joseph C. Bunten, chairman of the contest committee, suggests that county medical societies sponsor a local contest, selecting the three best papers for submission to the national contest. Essays must be received by the Association, 11 South La Salle Street, Chicago 3, by April 30 for entry in the national contest.

The American College of Radiology and the Philadelphia Roentgen Ray Society will sponsor a postgraduate course in radiology, March 30-April 4, in Philadelphia, for one hundred radiologists. Preference will be given to radiologists who served in World War II, with second preference going to qualified applicants who were unable to obtain admission to last year's course. Neoplastic and inflammatory diseases, carcinoma of the head and neck, dosage calculation and tumor sensitivity to radiation therapy, carcinoma of the breast, blood and hemopoetic diseases, carcinoma of the genital and urinary tract, benign and malignant diseases of the skin, and other subjects will be intensively studied. Additional information may be obtained from the American College of Radiology, 20 North Wacker Drive, Chicago 6.

The American Board of Ophthalmology is publishing a directory of its diplomates, to be arranged alphabetically and geographically, without biographical material. An effort is being made to secure names and addresses as they should appear. Diplomates who have not been contacted otherwise should send this information to the executive offices, Cape Cottage, Maine. The board has also announced that 1947 examinations will be held in Atlantic City, June 8-13; Philadelphia, June 13-16; and Chicago, the week of October 8.

The American Board of Psychiatry and Neurology has announced May 15-17 as the tentative dates for the next examination session, according to *The Journal of the American Medical Association.* Applications to take the examinations, which will be held in Philadelphia, must be in the hands of Dr. F. J. Braceland, Secretary, 102-110 Second Avenue S. W., Rochester, Minn., by March 1.

Mercy Hospital (Brownsville) Physicians Will Donate Their Services to a prenatal clinic, well-baby clinic, and tuberculosis clinic, the Brownsville *Herald* reports. The Junior Service League of Brownsville plans to establish a prenatal clinic, and a tuberculosis clinic will be established by the Cameron County Tuberculosis Association, supported largely through the sale of Christmas seals. The medical program of the clinics will be under the direction of the city and county physicians. The Mercy Hospital staff voted unanimously to support the clinics.

The Veterans Administration has announced that the hospital at Dallas is one of seventeen Veterans Administration hospitals equipped with a permanent iron lung, formerly standard equipment in only four such hospitals. Within a short time a similar lung will be installed in the hospital at Amarillo. Veteran patients requiring continued artificial respiration may be transferred to the nearest Veterans Administration hospital having an iron lung or, when travel is not possible, the apparatus may be shipped to the veteran.

Dallas will soon be the site of a Veterans Administration artificial eye and restoration clinic, at which eligible veterans may either be fitted with new plastic eyes or have repairs and alterations made to those they are wearing. Later the services of fitting and repairing plastic noses, ears, and hands will be added. Clinics are already in operation in eight cities throughout the nation, and Dallas is one of six additional cities scheduled to have the clinics in the near future.

The San Angelo Clinic-Hospital has enlarged its facilities by moving all physicians' offices to a new building around the corner from the hospital but connected with it, reports the San Angelo *Standard.* Formerly an apartment building, the new structure has been remodeled to accommodate physicians who previously occupied sixteen offices in the old building. This space is being converted into single hospital rooms, making a total of fifty-six beds available for patients.

Hospital Staff Officers have been named at several institutions recently. Dr. R. H. Engledow has been elected president of the Beaumont Municipal Hospital staff; Dr. W. J. Graber, vice-president; Dr. P. N. Fortney, secretary; Dr. Norman Duren, chief of surgery; and Dr. Seab Lewis, chief of medicine, informs the Beaumont *Journal.*

Memorial Hospital, Houston, staff officers recently elected include Drs. J. G. Heard, president; R. F. Bonham, vice-president; and Edward Crocker, secretary, the Houston *Chronicle* states. At Jefferson Davis Hospital, Houston, Dr. W. S. Red, Jr., has been named chief of the medical staff with Drs. Ralph C. Patrick, vice-chief; F. A. Bloom, secretary; Clyde M. Warner, chief of surgery; and W. A. Clark, chief of medicine. Dr. George F. Adam is the new chief of staff of the maternity division of St. Joseph's Infirmary, Houston, and Dr. John Wall is the new secretary. The Methodist Hospital, Houston, staff will be headed by Drs. John T. Stough as president; Emile Zax, president-elect; J. Roy Theriot, vice-president; and Ruth Hartgraves, secretary.

Hendrick Memorial Hospital, Abilene, according to the Abilene *Reporter-News,* has the following new officers: Drs. L. F. Johnson, Abilene, chairman of the medical staff; J. C. Duff, Anson, vice-chairman; Floyd Taylor, Abilene, secretary; R. W. Var-

ner, Abilene, chief of surgery; and J. N. Burditt and George W. Thurman, Abilene, executive committeemen.

Nazareth Hospital, Mineral Wells, will be served by the following officers: Drs. R. H. Smith, president; R. C. Jordan, vice-president; Ben L. McCloud, Jr., secretary; Don McCall, records chairman; W. B. Lasater, chief of surgical service; John Allensworth, chief of medical service; C. R. Williams, chief of eye, ear, nose, and throat; Edward F. Yeager, chief of x-ray; Ben L. McCloud, Jr., chief of obstetrics; W. B. Lasater and C. R. Williams, executive committeemen; and C. R. Williams, program chairman, reports the Mineral Wells *Index*. All named are of Mineral Wells except Dr. Smith, whose home is Palo Pinto.

Bethania Hospital, Wichita Falls, has announced the following staff officers: Drs. Bailey R. Collins, president of the executive board; K. W. McFatridge, vice-president; Harry Ledbetter, secretary; J. R. Reagan, assistant secretary; J. A. Heymann, P. K. Smith, and R. L. Daily, members of the executive board. The Wichita Falls *Times* indicates that the executive board has also appointed chiefs of the various departments.

Texas Medical Center.—A 200-bed children's hospital to cost $2,000,000 is being planned for the Texas Medical Center, Houston, by the Pediatrics Society of Houston. Announcement of the proposed hospital was made in December by Dr. E. W. Bertner, president of the center, who indicated that the hospital will embrace a crippled children's hospital (perhaps in conjunction with the Shrine hospital, for which funds are now being raised), a pediatric medical hospital, a surgical hospital, a year-round postgraduate teaching division, research foundation, neuropsychiatric institution, and a division of pediatric hygiene and public health. Reports in the Houston *Post* indicate that the newly proposed institution will not encroach on the general hospitals now existing or planned for the center. Need for additional beds for children has been emphasized by the Texas Child Health program leaders and by a survey recently made for the center by nationally known hospital consultants.

Texas Methodists during February are conducting a campaign for funds to erect an eight-story, $3,000,000 Methodist Hospital in the Texas Medical Center, according to the Houston *Post*. The main structure will house a chapel, emergency room, administrative offices, lounge, general kitchen, dining room, and pharmacy on the first floor, with provision for medical, surgical, maternity and nursery, operating, pathologic, and x-ray departments on the other levels. Adjoining the hospital will be a nurses home with accommodations for 250 student nurses. The school of nursing will include laboratories, class rooms, assembly space, and recreational facilities.

Baylor University College of Medicine, Houston, has announced a six months residency training program in the basic sciences to begin July 1. Anatomy, pathology, physiology, biochemistry, pharmacology and toxicology, parasitology, bacteriology, and hematology will be covered in the special course, details of which may be obtained from the Dean, Baylor University College of Medicine, Houston.

A Geiger-Muller counter for measuring radiation from radioactive materials has been donated to the Baylor University College of Medicine by Mr. and Mrs. M. F. Klicpera, Houston, in memory of their late son, David, according to the Houston *Post*. The instrument was made by Dr. G. C. Lechenger, assistant professor of radiology, from material furnished by Mr. and Mrs. Klicpera. The instrument was received December 30 by Dr. Joseph H. Gast, chairman of the department of biochemistry, in a simple ceremony, during which Bishop Clinton S. Quin blessed the gift. Dr. Carroll Handley, associate professor of physiology and pharmacology, and Dr. Gordon Robertson, assistant professor of anatomy, will begin experiments with radioactive iodine as soon as a supply of the element can be secured.

The University of Texas Medical Branch has announced receipt of several grants recently, according to the Galveston *Tribune*. The Texas Division of the American Cancer Society has contributed $5,700 to support the school's cancer clinic. Dr. John G. Sinclair, professor of histology and embryology, was given a grant of $2,000 to further his studies on the correlation of sickness and death occurring prior to, during, or immediately after birth in relation to the blood picture and other factors. Dr. Mildred Stanley, Tyler, a graduate of the medical school, has established the Mildred Stanley loan fund for women medical students. A loan of $250 will be available annually for a needy women student. The Pilot Club, a business and professional women's organization of Galveston, has offered $3,600 for a public health field instructor to work in conjunction with the public health department of the John Sealy College of Nursing.

Assets of the Rosalie B. Hite Endowment for Cancer Research with a book value of $315,080 have been assigned by the Board of Regents of the University of Texas for completing and equipping a cancer research laboratory at the M. D. Anderson Hospital for Cancer Research when it becomes a part of the Texas Medical Center in Houston, reports the Austin *Statesman*. The structure and equipment so provided will be designated in memory of the late Miss Hite. The assets assigned for the laboratory include bonds and stocks, notes, and real estate in Houston and California. Not assigned is real estate in Dallas with a book value of $373,333, which produces an income of approximately $26,000 used to finance fellowships in cancer research.

Dr. John G. Sinclair, professor of histology and embryology at the University of Texas Medical Branch, was recently elected president of the Texas Academy of Science, the Galveston *News* informs.

Dr. A. C. Broders, Mayo Clinic, Rochester, Minn., and Dr. Richard B. Cattell, Lahey Clinic, Boston, have been presented on the Phi Chi lecture series at the University of Texas, reports the Galveston *News*. Dr. Lester Reynold Dragstedt, professor of surgery at the University of Chicago, will appear March 13.

Southwestern Medical College has received a five-year grant of $2,500 for the establishment of "The Charles P. Guerriero, Sr., Memorial Lectureship in Obstetrics and Gynecology," informs the Oak Cliff *Tribune*. The fund, given by Dr. William F. Guerriero, Dallas, and George W. Guerriero, Monroe, La., in memory of their father, will be administered by a board consisting of Mr. Guerriero, Dr. W. Lee Hart, dean of Southwestern Medical College; Dr. William F. Mengert, chairman of the department of obstetrics and gynecology, and one other member. The lectures will be open to physicians, medical students, nurses, and interested persons in allied professions.

The trustees of the Southwestern Medical College have authorized affiliation of the college with the Veterans Administration Hospital at Waco. The college will appoint specialists in a consultant capacity to augment the medical service to patients in the hospital and will sponsor a resident training program. Similar agreements are already in force between the college and Veterans Administration hospitals in Dallas and McKinney, reports the Waco *News-Tribune*. Drs. Stephen Weisz, neuropathology; Robert Lackey, physiology; and Willard B. Weary, neurosurgery, have been nominated as consultants for the Waco hospital, an institution with 2,214 beds. Dr. George T. Caldwell, professor and chairman of the department of pathology, had also been nominated as consultant prior to his recent death.

Personals

Dr. W. Compere Basom, El Paso, attended a postgraduate course in the treatment of infantile paralysis at the Knickerbocker Hospital, New York, February 3-8, under sponsorship of the El Paso County Chapter of the National Foundation for Infantile Paralysis.

Dr. Octavio Garcia, McAllen, received multiple fractures of the right arm in an automobile crash in December, reports the McAllen *Monitor*.

Dr. L. F. Grubbs, Abilene, was flown home by chartered plane following an automobile collision near Shreveport, La., in December. He suffered two broken ribs and other injuries, the Abilene *Reporter-News* reports.

Dr. J. Milton White, Port Arthur, Jefferson County health officer for the past sixteen years, resigned effective January 1, according to the Beaumont *Enterprise*.

Dr. Horace Duncan, Dallas County health officer for fourteen years, resigned January 1 to join the medical staff of the Veterans Administration, the Dallas *News* reports.

Dr. J. R. Turner, former Midland health officer, is the newly appointed director of the Cameron County Health Unit with offices in San Benito, states the Brownsville *Herald*. The unit had previously been under the direction of a sanitarian, and has been raised to the rank of a standard health unit by appointment of a recognized physician as director.

Dr. Clinton E. Adams, Abilene, has been promoted to the rank of colonel in the Medical Reserve corps, reports the Abilene *Reporter-News*. Dr. Adams saw active duty in World Wars I and II.

Dr. and Mrs. J. F. McKissick, Arlington, celebrated their golden wedding anniversary with an open house at their home December 1, reports the Arlington *Journal*.

Dr. and Mrs. Branwell Fanning Stevens, El Paso, have announced the marriage of their daughter, Sara Elise to Frank Gillespie McKnight in El Paso on December 26, reports the El Paso *Times*.

Dr. and Mrs. Emmett Grady Causey, El Paso, have announced the marriage of their daughter, Barbara Gene, to Joseph Harlan Tooley on December 29 in El Paso, according to the El Paso *Times*.

Marriages

Dr. Gaylord A. Hart, Dallas, and Mrs. Anne Calcough Longfellow were married in Lamar, S. C., on September 29.

Dr. Michael K. O'Heeron and Miss Scharmayn Olsen were married in Houston on October 19.

Births

To *Dr. and Mrs. Charles D. Reece*, Houston, a daughter, born November 29.

To *Dr. and Mrs. Justin E. Bell*, Houston, a daughter, born in September.

To *Dr. and Mrs. Palmer E. Wigby*, Houston, a son, born November 20.

SOCIETY NEWS

Angelina County Society

January 13, 1947

(Reported by James C. Klein, Secretary)

Gail Medford, Lufkin, newly elected president, presided over the annual banquet of Angelina County Medical Society on January 13. Nineteen members and their guests were present.

Austin-Waller Counties Society

December 10, 1946

(Reported by R. A. Neely, Secretary)

Twenty members and guests of the Austin-Waller Counties Medical Society and Auxiliary were present for a turkey dinner given by Dr. and Mrs. O. E. Steck at their home in Bellville on December 10. Following the dinner the two groups met separately to elect officers. The medical society elected the following: H. E. Roensch, Bellville, president; S. C. Walker, Hempstead, vice-president; R. A. Neely, Bellville, secretary-treasurer; J. A. Neely, Bellville, F. W. Hover, Sealy, and V. Gordon, Sealy, censors; S. C. Walker, R. A. Neely, and V. Gordon, committee on public health and legislation; J. A. Neely, delegate; S. C. Walker, alternate.

Bee-Live Oak-McMullen Counties Society

December 16, 1946

(Reported by D. W. Davis, Secretary)

A resolution endorsing passage of a proposed basic science law by the Fiftieth Legislature was adopted by the Bee-Live Oak-McMullen Counties Medical Society on December 16 at the home of Tom B. Reagan, Beeville, president.

New officers were elected as follows: C. D. Gipson, Three Rivers, president; G. W. Sansom, George West, vice-president; D. W. Davis, Three Rivers, secretary-treasurer and delegate; and C. M. Poff, Tuleta, alternate. L. W. Kirkland, Beeville; G. W. Sansom, George West; and C. D. Gipson, Three Rivers, were named to the hospital committee. E. E. Miller, Beeville, will serve on the committee on public relations and medical legislation with L. W. Kirkland and J. W. Edmondson, both of Beeville, who were named to the committee last year.

Recent activities of the Texas Physicians Committee were discussed by E. E. Miller, Beeville, and D. W. Davis, Three Rivers.

C. D. Williamson, Three Rivers, who has retired after fifty years of practice, was elected to honorary membership.

Bell County Society

December 4, 1946

(Reported by O. B. Gober, Secretary)

Presentation of a Case of Rabies—Joe Barnhart, Beeville.

Bell County Medical Society, meeting at the Kyle Hotel, Temple, on December 4 with thirty-two members and six guests, voted to endorse passage of a basic science law by the Fiftieth Legislature. Upon motion of G. V. Brindley, Temple, the legislative committee, composed of A. F. Wolf, Rudolph K. Harlan, and Terrell Speed, all of Temple, was authorized to draw up a resolution.

Joe Barnhart, Beeville, discussed a case of rabies.

Officers for 1947 are as follows: O. B. Gober, president; Travis Smith, vice-president; J. G. Rodarte, secretary-treasurer; V. M. Longmire (re-elected for three years), J. W. Pittman (serving second year), and L. W. Pollok (serving third year), board of censors; A. C. Scott, delegate; A. F. Wolf, L. R. Talley, and J. W. Pittman (serving second year of two-year term), alternate delegates. Dr. Pittman resides in Belton, the other officers in Temple.

Albert Dabney Hurt was unanimously elected to membership upon application.

Announcement was made by Dr. Brindley that the Twelfth District Medical Society would meet in Temple on January 14 with C. C. Cody, Jr., Houston, President of the State Medical Association, as guest speaker at the luncheon.

Bexar County Society

New officers of the Bexar County Medical Society have been chosen as follows: J. L. Cochran, president; Thomas W. Sharp, vice-president; T. A. Pressly, treasurer; and J. W. Winter, secretary. All are from San Antonio.

Brown-Comanche-Mills-San Saba Counties Medical Society

December 9, 1946

(Reported by P. M. Wheelis, Secretary)

Intrathoracic Pain: Mortal or Inconsequential—Victor E. Schulze, San Angelo.
Low Back Pain and Its Treatment—Perry J. C. Byars, San Angelo.

Auxiliary members were guests of Brown-Comanche-Mills-San Saba Counties Medical Society for dinner preceding the regular meeting of the society at Hotel Brownwood on December 9. Twenty-seven members and guests were present.

The scientific program outlined above, presented by guests from San Angelo, was followed with a discussion by Victor E. Schulze, San Angelo, and O. N. Mayo, Brownwood, on physical examination vs. roentgen ray in the diagnosis of pericardial effusion. It was pointed out that as roentgen diagnosis has improved, physical examination has been neglected.

The society voted to send to each of its members copy of a recent letter to each druggist in the area condemning the practice of rebates on prescriptions.

New officers were elected as follows: Joe R. McFarlane, president; Fielding M. Pope, vice-president; Paul M. Wheelis, secretary-treasurer; Ben M. Shelton, delegate; Frederick W. Farley, alternate; and Ben M. Shelton, censor. Brownwood is the home of all but Dr. Farley, who resides in San Saba.

Cherokee County Society

November 26, 1946

Twenty-two members and guests of Cherokee County Medical Society were present for a meeting of the society November 26 at Rusk State Hospital. J. S. Scarborough and the hospital medical staff were hosts. Dr. and Mrs. Frank D. Patillo, Terrell, showed motion pictures of the South Pacific islands and the European theater.

Coleman County Society

December 5, 1946

Skin Grafting Using the Padgett-Hood Dermatome Method—Paul Wheelis, Brownwood.

Coleman County Medical Society held its annual banquet at the Coleman Hotel on December 5 with seventeen members and guests present. Paul Wheelis, Brownwood, presented a paper on skin grafting, which was discussed by H. B. Allen, Brownwood, and F. M. Burke, Coleman.

New officers, all of Coleman, include C. O. Moody, president; J. C. Young, vice-president; M. E. Weaver, secretary-treasurer.

Colorado-Fayette Counties Society

December 10, 1946

(Reported by C. I. Shult, Secretary)

Hemorrhage of the Respiratory Tract (lantern slides)—Robert E. Parrish, San Antonio.
Mal Implantation of Mesentery and Kidney Disorders Producing Backaches—O. J. Potthast, San Antonio.

Colorado-Fayette Counties Medical Society entertained the auxiliary with a dinner at the San Jacinto Hotel, Weimar, on December 10, after which a scientific program was presented under the direction of Adolph Potthast and Thomas Youens, both of Weimar. Discussion followed the papers by Robert E. Parrish and O. J. Potthast, guest speakers from San Antonio.

Denton County Society

December 5, 1946

Officers of the Denton County Medical Society were elected December 5 as follows: Walter S. Miller, president; Bert Davis, vice-president; Bobby Short, secretary-treasurer; William H. Magness, censor; Albert Wyss, delegate; and L. C. Lund, alternate. All are residents of Denton.

A committee composed of Harry Farber, Dr. Wyss, and Dr. Davis was appointed to consult with the Denton County Welfare Association.

DeWitt County Society

December 18, 1946

F. A. Prather, Cuero, was elected president; Chauncey Milner, Yoakum, vice-president; and A. J. Bohman, Cuero, secretary-treasurer, when DeWitt County Medical Society met December 18 at Cuero.

El Paso County Society

January 14, 1947

(Reported by W. Compere Basom, Secretary)

Wartime Research in Chemotherapy of Malaria—Branch Craige, Jr., El Paso.

J. E. Morrison, president; W. H. Stevenson, president-elect; W. R. Curtis, vice-president; and W. Compere Basom, secretary-treasurer, conducted their first meeting when El Paso County Medical Society met January 14. One hundred eleven of the 164 members were present for the session, which was held in the Turner Home, El Paso. The two-story house, a show place when it was built in 1910, was bequeathed by the late Dr. S. T. Turner to the medical society. Mrs. Turner was given a life interest in the house, but arrangements have been made in recent months for the El Paso County Medical Society and Auxiliary to take possession. The house has been remodeled to provide for meeting space, a medical library, and the doctors' exchange.

The society heard Branch Craige, Jr., El Paso, speak on wartime research in the chemotherapy of malaria. Chester D. Awe, El Paso, opened a general discussion.

Russell L. Deter, El Paso, reported on the condition of the El Paso City County Hospital. Recommendations were outlined for the improvement of services, and a motion was made that all members of the society participate in the work of the hospital.

Kenneth C. Baker, A. L. Perry, F. C. Golding, Ross W. Rissler, Robert F. Boveri, and James R. Herz were elected to membership upon application.

A suggested amendment to the By-Laws dealing with the time of meeting failed to pass. Meetings will therefore continue on every second and fourth Monday from September to May, inclusive.

Announcement was made that L. O. Dutton, El Paso, had been elected to charter membership in the International Association of Allergists, which will hold its first meeting in Paris in 1948.

Falls County Society

January 13, 1947

(Reported by Neil D. Buie, Jr., Secretary)

Surgical Operations for Disturbances of the Back (lantern slides)—Joe B. Foster, Houston.

Fifteen members of Falls County Medical Society and six visitors from the McLennan County Society met for dinner and a program at the Falls Hotel, Marlin, on January 13.

Joe B. Foster, Houston orthopedist, discussed 2,000 cases of low back pain occurring over a period of ten years. Of this group 124 were diagnosed as ruptured nucleus pulposus. Of these, 50 per cent were proved at surgery, 59 spinal fusions were performed, and 1 death was attributed to anesthesia. Dr. Foster discussed the important points in the history and physical examination of a case of ruptured nucleus pulposus.

Application for membership by Brewer D. Wheelis, Rosebud, was unanimously approved.

Galveston County Society

December 21, 1946

Galveston County Medical Society met December 21 at the Galveston Country Club. The following of-

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COLLEGE OF PHYSICIANS

ficers were elected: John McGivney, Galveston, president; Andrew Magliolo, Dickinson, vice-president; E. J. Lefeber, Galveston, secretary. J. L. Jinkins, Galveston, was appointed to the board of censors.

The society accepted an invitation from Jack Ewalt, director of the Galveston State Psychopathic Hospital, to hold a dinner meeting in January at the hospital. Plans were made to hold monthly dinner meetings.

Gonzales County Society

December 7, 1946

(Reported by C. C. Cogburn, Secretary)

History of the Gonzales Warm Springs Foundation for Crippled Children—John Babcock, Gonzales, Member of the Foundation Committee.

Significance of the Enlargement of the Thymus Gland in Infants—Robert E. Leaton, Resident in Pediatrics, University of Texas Medical Branch, Galveston.

Recent Advances in the Treatment of Congenital Syphilis—Erle E. Wilkinson, Associate Professor of Pediatrics, University of Texas Medical Branch, Galveston.

Gonzales County Medical Society was host to physicians from DeWitt, Hays, Guadalupe, and Caldwell Counties for a steak dinner and program in Gonzales on December 7.

John Babcock, lay member of the foundation committee for the Gonzales Warm Springs Foundation for Crippled Children, discussed the purpose, location, growth, and facilities for treatment at the foundation.

Two members of the University of Texas Medical Branch staff in pediatrics presented papers. Robert E. Leaton, resident in pediatrics, reviewed the literature on the clinical significance of the thymus gland and concluded that there is no proof that the thymus gland is of any clinical importance except in rare instances. Erle E. Wilkinson, associate professor of pediatrics, summarized the results of treating 64 patients with congenital syphilis by means of penicillin. In infants the results were dramatic, and penicillin is probably the treatment of choice. In children with late manifestations this therapy does not appear so effective on the schedules used to date, Dr. Wilkinson said. Several members of the society discussed the papers.

Gray-Wheeler Counties Society

(Reported by W. Purviance, Secretary)

Gray-Wheeler Counties Medical Society has elected the following officers for 1947: Frank Kelley, Pampa, president; H. E. Nicholson, Jr., Wheeler, vice-president; H. Y. Sygler, Shamrock, vice-president; K. W. Pieratt, Pampa, vice-president; W. Purviance, Pampa, secretary-treasurer; Julian Key, Pampa, censor; H. E. Nicholson, Wheeler, delegate; and Malcom Brown, Pampa, alternate.

Hardin-Tyler Counties Society

December, 1946

Nine members of Hardin-Tyler Counties Medical Society met in Kountze the middle of December. New officers elected include L. R. Lancaster, Sour Lake, president; T. A. Tennison, Silsbee, vice-president; W. H. Beazley, Silsbee, secretary; Watt Barclay, Woodville, delegate; and John Knight, Beaumont, alternate.

Hidalgo-Starr Counties Society

December 12, 1946

Etiology and Treatment of Acute Purulent Conjunctivitis—Thomas D. Allen, Rush Clinical Professor of Ophthalmology, University of Illinois College of Medicine, Chicago, and Edward W. Griffey, Houston.

Members of Hidalgo-Starr Counties Medical Society heard a preliminary report December 12 in Edinburg of the results of an investigation made several days previously of a disease of the eyes known locally as "Mexican sore eyes." The investigation was made by Thomas D. Allen, University of Illinois ophthalmologist, and Edward W. Griffey, Houston, ophthalmologist, who saw 200 patients with the disease during the clinic. Dr. Allen explained that the disease, a comparatively rare condition, is epidemiological in nature, is probably spread by gnats, and is self-limited. He advocated sanitary and personal cleanliness measures to eliminate the disease.

A motion picture explaining the action of the B complex vitamins was shown.

Officers elected at the meeting include Joe May, Edinburg, president; Carl Reed, San Juan, vice-president; Lloyd Southwick, Edinburg, secretary-treasurer; and Herbert M. Westphal, Weslaco, censor.

Hill County Society

December 13, 1946

J. E. Boyd, Hillsboro, was re-elected president of Hill County Medical Society at a dinner meeting in Hillsboro on December 13. Ben C. Smith, Hillsboro, was elected vice-president; Charles A. Garrett, Hillsboro, re-elected secretary-treasurer; Ben C. Smith, delegate; C. C. Campbell, Itasca, alternate; T. R. Barnett, Hillsboro, censor.

Hunt-Rockwall-Rains Counties Society

December 17, 1946

Hunt-Rockwall-Rains Counties Medical Society elected officers December 17 preceding a Christmas banquet given by the auxiliary at the Washington Hotel, Greenville. E. T. Crim was named president; Ralph Jenks, vice-president; Fred Peak, secretary; and W. B. Reeves, delegate. All live in Greenville.

Jefferson County Society

December 9, 1946

(Reported by L. R. Byrd, Jr., Secretary)

The annual meeting and banquet of Jefferson County Medical Society was held December 9 at the Goodhue Hotel, Port Arthur, with President George Sladczyk, Port Arthur, presiding.

The following officers for 1947 were elected by acclamation: Dudley English, Beaumont, president; Russell C. Willoughby, Groves, vice-president; Lamar Bevil, Beaumont, secretary-treasurer; L. C. Heare, Port Arthur, and L. C. Powell, Beaumont, delegates; R. R. Orrill, Port Arthur, and J. C. Crager, Beaumont, alternates; L. R. Byrd, Jr., Port Arthur, censor.

Upon motion by B. H. Vaughan, Port Arthur, seconded by T. B. Matlock, Port Arthur, the society voted to make Pat Reed, Port Arthur, an honorary member and to propose his name for honorary membership in the State Medical Association.

J. B. Morris was named attorney for the society for 1947, and O. D. Adamson was voted $100 for secretarial services during the past year. A contribution of $5 for the Beaumont and Port Arthur Tuberculosis Associations was voted.

Stuart Wier, Beaumont, moved that a committee be appointed by the president to study a disagreement between a society member and a Port Arthur labor union group. Following a second by C. H. Todd, Jr., Beaumont, the motion carried. The matter was referred to the legislative committee for study and report back to the society.

Before the meeting was adjourned a rising vote of thanks was given President Sladczyk for his leadership during the past year.

Johnson County Society

January 14, 1947

(Reported by J. G. Little, Secretary)

Johnson County Medical Society met at the Kimbro Clinic, Cleburne, on January 14, with nine present. A clinical-pathological conference was held, 2 cases from the records of the Massachusetts General Hospital as published in the *New England Medical Journal* serving as the basis for discussion. R. W.

Kimbro and W. R. Whitehouse, both of Cleburne, gave the principal discussion of the cases. The cases were discussed from the clinical records of the patients before the pathological records were made known. In each instance the reviewer arrived independently at the same opinion as the main speaker in a similar event at Boston, and after vigorous discussion, the other society members in the main agreed. The pathological reports were then read to disclose that both in Texas and in Boston the correct diagnosis was missed.

Kleberg-Kenedy Counties Society

December 11, 1946

(Reported by W. A. Ewert, Secretary)

Election of officers was held by Kleberg-Kenedy Counties Medical Society on December 11. Those elected include W. A. Ewert, president; L. P. Noel, Jr., vice-president; S. C. Dunn, secretary-treasurer; W. A. Ewert, delegate; and T. D. Reed, C. G. Brindley, and L. M. Barnett, alternates. All are from Kingsville except Dr. Barnett, who is from Bishop.

New officers were installed January 8.

Lamar County Society

(Reported by Robert L. Lewis, Jr., Secretary)

John A. Stephens, president; D. F. Kerbow, vice-president; and Robert L. Lewis, Jr., secretary-treasurer, all of Paris, will serve as officers of Lamar County Medical Society during the coming year.

Lubbock-Crosby Counties Society

January 7, 1947

(Reported by O. R. Hand, Secretary)

Intussusception: Reduction with Controlled Barium Enema—S. C. Arnett, Lubbock.

Thirty-seven members and three guests of Lubbock-Crosby Counties Medical Society met for dinner and a scientific and business session at the Negro hospital in Lubbock as guests of J. A. Chatman.

S. C. Arnett, Lubbock, presented a paper on intussusception. He noted that there is a mortality of 20 to 30 per cent in cases treated surgically, and reviewed the history of the use of a barium mixture under the fluoroscope to reduce intussusception, a method which has resulted in far less mortality. He outlined the symptoms and differential diagnosis involved, mentioning intermittent colicky abdominal pain, nausea and vomiting, diarrhea, tenesmus, blood and mucus in the stool, flaccidity of the abdomen, palpation of a sausage-like mass, and roentgen findings. He reported 5 patients who improved after intussusception was reduced by means of a barium enema and manipulation using a No. 16 Bardex catheter. All cases were of the ileocolic variety. It was noted that the barium can must be kept at a constant level and the catheter must not be clamped off. Dr. Arnett stated that the procedure requires considerable fortitude, that the time element is not of great importance, that the amount of circulatory damage is probably more important, but that no patients had required operation following reduction.

R. C. Douglas announced that he had been appointed to act with the Red Cross on a disaster committee for Lubbock County. He requested that two or more members be appointed to work with him, and President Pauline Miller appointed M. M. Ewing and E. M. Blake.

James W. Rollo brought up the subject of bringing a mobile tuberculosis case finding unit to Lubbock. Dr. Arnett said that this arrangement could be worked out only if a county health unit were formed. Upon his motion, seconded by Dr. Ewing, the matter was tabled.

Upon the report of the nominating committee, Allen T. Stewart, Lubbock, was elected delegate and Frank B. Malone, Lubbock, alternate, both by acclamation.

Dr. Miller appointed the following committees, all members of which are of Lubbock: legislation and public relations, Allen T. Stewart, Henrie E. Mast, and Olan Key; program, Roy Loveless, Roy Riddle, Jr., and Robert H. McCarty; public health, James W. Rollo, William L. Baugh, and A. G. Barsh.

Several communications were read.

The invitation of Dr. Chatman to return to the hospital for the May meeting was accepted. Other meetings will be held at the Plains Clinic, Lubbock.

Nacogdoches County Society

December 11, 1946

(Reported by Henry Tucker, Secretary)

Nacogdoches County Medical Society elected the following officers on December 11: C. T. Smith, president; C. F. Neuville, vice-president; and James G. Taylor, secretary. All the new officers reside in Nacogdoches.

Navarro County Society

December 20, 1946

(Reported by Paul H. Mitchell, Secretary)

Officers for 1947 were elected by Navarro County Medical Society on December 20. The new leaders include, from Kerens, Gurley H. Sanders, president and alternate; and from Corsicana, William R. Sneed, vice-president; Paul H. Mitchell, secretary; T. O. Wills, W. W. Carter, and L. E. Kelton, censors; Will Miller, legislative and public relations committee; and J. Wilson David, delegate.

Nueces County Society

December 3, 1946

(Reported by R. J. Sigler, Secretary)

Nueces County Medical Society on December 3 elected the following officers for 1947: Foy H. Moody, president; Alvin Ashmore, vice-president; Robert J. Sigler, secretary-treasurer; G. Turner Moller and John Pilcher, delegates; L. M. Garrett and McIver Furman, alternates; and R. G. Swearingen, censor. All those named are from Corpus Christi.

Palo Pinto-Parker Counties Society

December 10, 1946

Diagnosis of Heart Disease and Usages of the Electro-Cardiograph—E. Y. Yeager, Mineral Wells.

Palo Pinto-Parker Counties Medical Society honored physicians who have returned from military service and new members of the organization at a dinner meeting December 10 at Nazareth Hospital, Mineral Wells. E. F. Yeager, Mineral Wells, presented a paper, and new officers were elected. C. R. Williams, Mineral Wells, was elected president; H. C. Allen, Weatherford, vice-president; John Allensworth, Mineral Wells, secretary-terasurer; Don McCall, Mineral Wells, delegate; E. M. Russell, Weatherford, alternate; and C. R. Williams and R. H. Smith, Palo Pinto, censors.

Pecos-Jeff Davis-Presidio-Brewster Counties Society

January 5, 1947

(Reported by W. E. Lockhart, Secretary)

Low Back Pain (lantern slides)—J. C. Byars, Jr., San Angelo.

Members of the Pecos-Jeff Davis-Presidio-Brewster Counties Medical Society were entertained by Fort Stockton physicians at the January 5 meeting. Six members and seven guests heard J. C. Byars, Jr., San Angelo, discuss low back pain. Dr. Byars emphasized the shortcomings of intervertebral disk etiology of pain and the importance of the articular facets.

Upon motion by C. E. Oswalt, Fort Stockton, seconded by W. E. Lockhart, Alpine, the society unanimously endorsed passage of the basic science bill in Texas.

A resolution was adopted in tribute to Dr. William Harrison Moore, Fort Stockton physician for twenty-eight years, who died December 12, 1946.

Potter County Society

January 13, 1947

(Reported by George M. Waddill, Jr., Secretary)

Fasciolate Transplant in Regression of Retrotarsal Fat (motion picture)—Weldon O. Murphy, Amarillo.

Potter County Medical Society met January 13 in Amarillo with twenty-six members and seven guests in attendance. The visitors included two representatives of the Blue Cross plan, three members of the Veterans Facility at Amarillo, and two physicians.

The scientific program consisted of a paper and motion picture on fasciolate transplant in regression of retrotarsal fat by Weldon O. Murphy, Amarillo.

Mr. Harley B. West, Dallas, a representative of the Blue Cross, explained the features of the hospitalization plan and medical and surgical plan of the organization. He proposed that Potter County Medical Society formally endorse the Blue Cross plan, enroll as a society in the plan, and create a committee to coöperate with the Blue Cross Association. Upon motion by E. A. Rowley, Amarillo, the society voted to endorse the Blue Cross plan. Discussion on the motion brought out the fact that the medical and surgical plan does not limit the fee a doctor may charge but does stipulate the amount which will be paid by Blue Cross. Howard Puckett, Amarillo, also pointed out that Potter County Medical Society had endorsed the Blue Cross plan several years ago and had contributed money to help get the plan started.

John M. Hooper was unanimously elected to membership upon application.

Several communications were read by the secretary.

Randall-Deaf Smith-Parmer-Castro-Oldham Counties Society

January 8, 1947

(Reported by Robert P. Jarrett, Secretary)

Pneumonia—Leo Duflot, Canyon.

Randall-Deaf Smith-Parmer-Castro-Oldham Counties Medical Society met in Canyon on January 8, with nine members and guests present. Leo Duflot, Canyon, presented a paper on pneumonia, which was discussed by the entire group.

Dr. Duflot was elected delegate, and R. A. Neblett, Canyon, and R. R. Wills, Hereford, were named to the committee on legislation and public relations.

Refreshments were served following the meeting.

Reeves-Ward-Winkler-Loving-Culberson-Hudspeth Counties Society

(Reported by L. C. Hanes, Jr., Secretary)

Reeves-Ward-Winkler-Loving-Culberson-Hudspeth Counties Medical Society has named W. H. McClure, Kermit, president; Harold Lindley, Pecos, vice-president; and L. C. Hanes, Jr., Wink, secretary, for 1947.

Smith County Society

January 9, 1947

(Reported by William M. Bailey, Secretary)

Surgical Treatment of "Blue Babies"—John W. Duckett, Dallas.
Operative Care of Peptic Ulcers—H. Walton Cochran, Dallas.

Smith County Medical Society met January 9 in the dining room of Mother Francis Hospital, Tyler, with thirty-six members and twelve visitors present.

Two Dallas physicians presented the scientific program. John W. Duckett discussed the surgical treatment of "blue babies." He showed by lantern slides the type of congenital defect these children have and how surgery has been able to correct the defect, so that now children who previously were almost certainly doomed to death before they were 15 years old are, in a large percentage of cases, made comfortable and allowed to take their place in life. He said that much is being done to improve the diagnosis and technique of handling such cases.

H. Walton Cochran spoke on the operative care of peptic ulcers. He reviewed the physiology and anatomy of the nerve supply of the stomach and showed how the destruction of the nerve supply will decrease the activity of the stomach, thus allowing ulcers to heal more readily. He stressed the fact that this treatment does not replace medical treatment and should be reserved for cases which do not respond satisfactorily to medicine.

C. C. McDonald, Tyler, thanked the society for its response in subscribing to the Industrial Foundation Committee, which, he reported, has arranged to bring in several new industries.

E. H. Caldwell, Tyler, reporting on the Physiotherapy Center, said that 46 patients had been treated and that another trained physiotherapist is being secured to help care for the patients. He stated that the center is open to the physicians of East Texas and invited society members to send in patients requiring treatment.

C. B. Young, Tyler, secretary of the Eleventh District Medical Society, announced that the spring meeting of the society will be held in Tyler with several outstanding speakers scheduled to appear.

Tarrant County Society

December 17, 1946

(Reported by W. P. Higgins, Secretary)

The Texas Physicians Committee and Its Relation to the National Physicians Committee—X. R. Hyde, Fort Worth.
The Status of the Veterans Program in Texas—Tom B. Bond, Fort Worth.

Thirty members and three visitors were present at a meeting of Tarrant County Medical Society in the Medical Arts Auditorium, Fort Worth, on December 17.

Upon motion by Tom B. Bond, Fort Worth, seconded by T. C. Terrell, Fort Worth, it was decided to establish adjudication and preceptorship committees in line with suggestions made by the State Medical Association.

X. R. Hyde, Fort Worth, explained the Texas Physicians Committee and its relation to the National Physicians Committee, and the relation of each to regularly organized medicine. He outlined the purposes of the Texas group. C. O. Terrell, Jr., R. B. Anderson, H. R. Hathaway, W. B. West, and T. L. Goodman, all of Fort Worth, discussed the subject.

Dr. Bond reported that the Council on Medical Economics of the State Medical Association has been working for the past six months with the Veterans Administration in an attempt to establish a statewide agreement regarding treatment of veterans. A questionnaire sent to each county medical society in the state was used as a basis for working out a representative fee schedule by the Council, and the regional office of the Veterans Administration has tentatively accepted the schedule. It has now gone to Washington for final approval, after which it will be returned to the State Medical Association for submission to the county medical societies for their approval or rejection. W. F. Ossenfort, W. B. West, W. W. Sumner, C. O. Terrell, Jr., Ted Lace, and Mal Rumph all of Fort Worth, discussed Dr. Bond's presentation.

Tribute was paid Mrs. T. G. Rumph, Fort Worth, wife of T. G. Rumph, who died December 4.

January 7, 1947

(Reported by W. P. Higgins, Jr., Secretary)

Present Status of Immunizations Against Infectious Diseases—Harold M. Williams, Fort Worth.
Usual and Unusual Complications of Diphtheria—John M. Church, Fort Worth.

Tarrant County Medical Society met in Fort Worth on January 7 with eighty-two members and four visitors present. The scientific program outlined above was presented. E. G. Schwarz, James N. Walker, and I. P. Barrett discussed the paper by Dr. Williams. J. F. Campbell, J. F. McVeigh, Frank W. Halpin, R. J. White, Harold M. Williams, and T. C. Terrell discussed the paper by Dr. Church.

May Owen addressed the society before assuming the office of president. She introduced Sim Hulsey, chairman of the program committee, who outlined the committee's plans for the year.

Emory Davenport, H. R. Hathaway, Oscar L. Morphis, and V. H. Shoultz were elected to membership upon application.

Announcement was made by the secretary that the Thirteenth District Medical Society would meet in Abilene sometime in the spring and that those wishing to present papers then should contact Robert C. Stokes, Fort Worth, district secretary.

Taylor-Jones Counties Society

December 16, 1946

Approximately 120 persons were present for the annual banquet of Taylor-Jones Counties Medical Society in Abilene on December 16. The auxiliary was host for the affair.

New officers elected at the banquet, all Abilene physicians, include Clinton E. Adams, president; Jack A. Crow, vice-president; and L. J. Webster, secretary.

Travis County Society

(Reported by H. L. Hilgartner, Secretary)

Travis County Medical Society in December elected officers for the coming year as follows: O. W. Suehs, president; Charles B. Dildy, vice-president; Joe T. Gilbert, secretary-treasurer; Charles P. Hardwicke, delegate; and Sam N. Key, alternate. All are of Austin.

N. A. Kilgore, Houston, was guest of the society and showed photographs which he had taken while overseas.

Webb-Zapata-Jim Hogg Counties Society

December, 1946

Symposium: Diseases of the Thyroid Glands—John T. Lowry, Ruby South Lowry, S. H. Graham, W. R. Powell, and F. M. Canseco, Laredo.

Webb-Zapata-Jim Hogg Counties Medical Society met in December at the Plaza Hotel, Laredo, for a symposium on thyroid gland diseases, as noted above. Special emphasis was placed on hyperthyroidism and the latest methods of treatment.

E. M. Longoria was elected president; G. E. Penny, vice-president; John T. Lowry, reëlected secretary-treasurer; F. M. Canseco, censor; and A. T. Cook, delegate. All are of Laredo.

Wichita County Society

(Reported by R. L. Daily, Secretary)

Wichita County Medical Society will be headed by J. B. Nail as president, R. L. Daily as vice-president, and K. W. McFatridge as secretary-treasurer, during 1947. All officers reside in Wichita Falls.

Twelfth District Society

January 14, 1947

(Reported by H. F. Connally, Jr., Secretary)

Sixty-three members and visitors attended the meeting of the Twelfth District Medical Society in Temple, January 14, 1947. It was decided to accept the invitation of Howard Smith to meet next in Marlin on July 8.

W. Howard Wells, Waco, was elected president; R. R. White, Temple, vice-president; and H. F. Connally, Jr., Waco, reelected secretary. G. V. Brindley, Temple, was renominated to serve as Councilor of the district.

Bell County Medical Society was host at a luncheon featuring C. C. Cody, Jr., Houston, President of the State Medical Association, as speaker. Other addresses were included on the scientific program as follows:

Traumatic Injuries of the Hand—W. Howard Wells, Waco.
The Treatment of Chronic Lung Abscess—Donald L. Paulson, Dallas.
Management of Renal Calculi—Vincent Vermooten, Dallas.
Some of the Newer Concepts in Thoracic Surgery—G. V. Brindley, Jr., Temple.
Management of the Edematous Patient—Travis Smith, Temple.
Surgical Aspect of Gastric Ulcer—R. R. White, Temple.
Some Urological Problems in Gynecology—Howard Smith, Marlin.

A. Ford Wolf and R. C. Curtis were members of the arrangements committee.

AUXILIARY NOTES

Officers of the Woman's Auxiliary to the State Medical Association of Texas: President, Mrs. George Turner, El Paso; President-Elect, Mrs. Edward C. Ferguson, Beaumont; First Vice-President, Mrs. L. B. Windham, Tyler; Second Vice-President, Mrs. V. M. Longmire, Temple; Third Vice-President, Mrs. R. E. Clark, Memphis; Fourth Vice-President, Mrs. J. E. Hogan, Big Spring; Corresponding Secretary, Mrs. Robert F. Thompson, El Paso; Recording Secretary, Mrs. M. A. Ramsdell, San Antonio; Publicity Secretary, Mrs. J. F. Campbell, Fort Worth; Treasurer, Mrs. Guy Jones, Dallas; Parliamentarian, Mrs. Joe Nichols, Atlanta.

AUXILIARY NEWS

Austin-Waller Counties Auxiliary was entertained with the medical society by Dr. and Mrs. O. E. Steck at their home in Bellville, December 10. Following a turkey dinner served from a table decorated with red candles and holly, the two groups met separately. The auxiliary elected Mrs. R. A. Neely, Bellville, president, and Mrs. H. E. Roensch, Bellville, secretary-treasurer. Sixteen guests were served by Mrs. Steck, assisted by her sisters, Mrs. Eddie Koerth and Mrs. Ed Dittert.

Bell County Auxiliary sponsored the showing of health films throughout the county during January, under the direction of Mrs. G. V. Brindley, Temple. A campaign to increase the sales of *Hygeia* was carried on at the same time.—Mrs. John E. Bauman, Publicity Chairman.

Bowie-Miller Counties Auxiliary entertained with a Christmas party December 10 at the home of Mrs. A. G. Lee, Texarkana. Forty-three members, their husbands, and guests were served refreshments from a table appointed in red and silver, centered with an arrangement of poinsettias. Guests were greeted by Mrs. Lee, Mrs. Roy Baskett, and Mrs. Ralph Cross. Assisting in the dining room were Mesdames Allen Collom, R. R. Kirkpatrick, and Harry Murry. Gifts were distributed from a gaily decorated tree.

El Paso County Auxiliary at its December meeting honored Mrs. George Turner, State Auxiliary president, who spoke on the program of the State and National Auxiliaries. Mrs. Turner had previously visited twenty-eight auxiliaries throughout the state. A tea was held following the talk, with Mesdames James L. Gorman, J. Leighton Green, and Ralph Homan as hostesses and Mesdames R. B. Homan, Jr., J. H. Hinton, W. R. Jamieson, Gerald Jordon, E. C. Johns, C. E. Jumper, N. H. Keller, Sam King, Jack King, J. W. Laws, T. C. Liddell, A. D. Long, K. D. Lynch, John D. Martin, C. H Mason, Paul McChesney, Ervin McNeil, Felix Miller, and John Morrison as cohostesses. Mrs. Russell Deter arranged the Christmas decorations.

El Paso County Auxiliary met January 13 in the Turner Home, El Paso, to hear Col. John E. Blaine discuss the Blue Cross hospital plan. Mrs. J. J. Gorman reported current medical events. Mrs. H. Earl Rogers and Mrs. John D. Peticolas were hostesses for the tea hour following the business session, assisted by Mesdames A. W. Multhauff, P. R. Outlaw, Palmer Reed, Charles Rennick, Sam Rennick, Paul Rigney, J. Rogde, J. B. Robbins, E. B. Rogers, F. R. Schuster, Stephen Schuster, T. E. Scott, T. J. B. Shanley, Francis Snidow, M. P. Spearman, and Celso Stapp. Mrs. Russell Deter was in charge of decorations.—Mrs. J. D. Martin, Publicity Chairman.

Falls County Auxiliary had a dinner meeting January 13 in Marlin. Ten members and one guest, Mrs. J. B. Foster, Houston, were present.—Mrs. J. B. Barnett, President.

Hunt-Rockwall-Rains Counties Auxiliary honored medical society members at an annual Christmas banquet December 17 at the Washington Hotel, Greenville. Nearly one hundred guests were present to hear a talk on "What Is Right with the World?" by the Rev. George Sagen, pastor of Washington Street Baptist Church. Mrs. W. P. Philips, Greenville, president of the auxiliary, presided. The Rev. H. C. Henderson, pastor of Kavanaugh Methodist Church, delivered the invocation; Dr. S. D. Whitten, Greenville, past president of the medical society, introduced incoming officers, who had been elected immediately preceding the banquet; and Mrs. Donald Course, Mrs. W. N. Miller, and Mrs. Mary Buchanan presented a musical program. Arrangements were in charge of Mesdames J. W. Ward, Wendell Pool, Fred Peak, and Anna Boykin. Garlands of red berries, holly, and poinsettias decorated the tables.

Jefferson County Auxiliary entertained members of the medical society at a Christmas dinner and party December 14 at the Edson Hotel, Beaumont. In charge of arrangements were Mesdames John Carter, E. D. Cunn, Walter D. Brown, Sr., and J. C. Crager.

Kerr-Kendall-Gillespie-Bandera Counties Auxiliary met December 13 in the home of Mrs. C. L. McClellan, Kerrville, with Mesdames A. P. Allison and H. H. Gallatin as cohostesses. Mrs. Northrop, secretary of the Tuberculosis Christmas Seal Sale sponsored by the auxiliary, reported on the amount received so far from the sale. She also introduced three high school students, Franklin Gagnard, Agnes Henks, and Meta Flora Real, who read essays on "Preventive Measures in Combating Tuberculosis." The three essays had won first, second, and third prizes, respectively, in a contest sponsored by the seal sale committee. Refreshments were served while Christmas carols were played.—Mrs. David McCullough, Publicity Secretary.

Liberty-Chambers Counties Auxiliary met January 9 in the home of Mrs. Frank Griffin, Liberty, to elect officers. Mrs. W. H. Bridges, Goose Creek, was named president; Mrs. Lloyd Fahring, Anahuac, vice-president; Mrs. Griffin, secretary-treasurer; and Mrs. Jack Bevil, Hull, parliamentarian. Mrs. Griffin presided over the business session, at which seven members were present. Refreshments were served during a social hour.—Mrs. E. R. Richter, Secretary.

Orange County Auxiliary met January 7 at the home of Mrs. C. E. Phillips, Orange, with Mrs. G. Y. Swickard as cohostess. Mrs. M. H. Bierman, Mrs. W. R. Thornton, and Mrs. Robert Shepherdson were received as members at large, and Mrs. Edward Becker and Mrs. George H. Kinser were enrolled as regular members. Mrs. Swickard led a program on new medicines, and Mrs. T. O. Woolley, president, conducted a business session. A social hour during which refreshments were served followed the meeting.—Mrs. T. O. Woolley, President.

Taylor-Jones Counties Auxiliary honored the medical society at a dinner December 16 at the Abilene Country Club. Mrs. L. J. Pickard, chairman of the entertainment, was assisted by Mesdames O. W. Little, W. A. V. Cash, Bruce Porter, and Guy Pattillo.

Tom Green-Eight County Auxiliary had a Christmas luncheon December 16 at the Hotel Cactus, San Angelo. Thirty members exchanged white elephant gifts from a lighted yule tree and heard a seasonal program given by guest artists. Mesdames George Nesrsta, Maynard Knight, Lewis Tester, and Victor Schulze were hostesses. Tables were decorated with red berries and red candles in silver candelabra.

The auxiliary on January 6 at the Massie Clubhouse, San Angelo, heard Mrs. C. E. Bludworth review "Fabulous Empire" by Fred Gipson. Mrs. Bludworth was introduced by Mrs. Victor Schulze. A tea hour followed the review, with Mrs. Jerome Smith and Mrs. R. M. Finks presiding at the tea table. Hostesses included Mesdames W. B. Butner, R. M. Arledge, Aubrey Lewis, D. D. Wall, Grady Mitchell, G. W. Nibling, and Kermit Brask. About one hundred guests attended.—Mrs. Victor Schulze, Publicity Secretary.

Travis County Auxiliary held its annual party honoring members of the medical society at the Austin Country Club, December 17. Christmas decorations were used throughout the club rooms and on the buffet. About one hundred guests were present. The hostess committee, headed by Mrs. L. C. Paggi, included Mesdames W. P. Morgan, H. L. Hilgartner, Paul White, J. A. Crockett, David Wade, Henry Paine, Robert J. Jaehne, S. H. Dryden, C. B. Dildy, and G. W. Cleveland.

DEATHS*

Dr. and Mrs. Joseph Corrigan, Jr., Conroe, Texas, were killed shortly before midnight October 28, 1946, when the private plane, piloted by Dr. Corrigan, in which they were flying, went into a spin at low altitude and crashed near the Conroe Airport. Dr. and Mrs. Corrigan and another couple were celebrating Mrs. Corrigan's birthday. The other man and Dr. Corrigan had returned from a flight, and the woman was awaiting her turn when the plane crashed. A low fog was blamed for the accident.

DR. JOSEPH CORRIGAN, JR.

Dr. Corrigan, son of Joseph and Nettie Corrigan, was born February 17, 1913, in Shreveport, La. He was graduated from Louisiana State University Medical School, New Orleans, in 1936, and served an internship at Charity Hospital, Shreveport. After practicing a year in Shreveport, Dr. Corrigan went to Conroe, where he had been active until his death.

Dr. Corrigan was a member of Montgomery County Medical Society, the State Medical Association, and American Medical Association. He was president of the Conroe Lions Club in 1942-1943, and was a member of the aviation committee of the Montgomery County Chamber of Commerce. He was also a member of Theta Kappa Psi medical fraternity.

*An obituary ordinarily will not be published more than four months after date of death. Coöperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

Miss La Verne Singletary and Dr. Corrigan were married September 18, 1935, in Shreveport, La. They are survived by a son, Joseph Corrigan, III; Dr. Corrigan's parents, Mr. and Mrs. Joseph Corrigan; and Mrs. Corrigan's mother, Mrs. Mabel Singletary, all of Shreveport.

Dr. Richard Bland Ford, Corpus Christi, Texas, died suddenly of heart disease at his home November 30, 1946.

The son of Mr. and Mrs. J. B. Ford, Dr. Ford was born April 8, 1901, at Monroe, Okla. He attended Oklahoma Agricultural and Mechanical College at Stillwater and received his bachelor of science degree from the University of Oklahoma, Norman, in 1926. In 1928 he was graduated from the University of Oklahoma School of Medicine, Oklahoma City. After serving a one year rotating internship, he remained for a two year fellowship in surgery at the Cleveland Clinic. Dr. Ford took a year of postgraduate work in surgery at the University of Vienna, Austria, in 1936. Dr. Ford practiced during 1931 in Tulsa, Okla. In 1932 he went to Holdenville, but returned in 1938 to Tulsa, where he was located until called to military service in 1940. He was stationed for two years in Corpus Christi as a naval officer, also serving at Pensacola, Fla., twenty-three months in the Pacific as a flight surgeon, and as head of the medical department of the naval base at Pasco, Wash. Upon his discharge from the Navy with the rank of commander, Dr. Ford began his practice in Corpus Christi in May, 1946, with Dr. M. J. Perkins.

DR. RICHARD B. FORD

Dr. Ford maintained his membership in the American Medical Association throughout his professional career. While practicing in Oklahoma, he was a member of the Tulsa County Medical Society and Oklahoma State Medical Association. At the time of his death he was a member of the State Medical Association of Texas through Nueces County Medical Society. He was also a member of the Association of Military Surgeons and of Beta Theta Pi fraternity.

On December 7, 1943, Dr. Ford married Miss Catherine Adelaide Dinn. Survivors include his wife, Corpus Christi; his mother, Mrs. J. B. Ford, and a brother, Joe Ford, both of Monroe, Okla.; and a sister, Betty Ford, New Orleans.

Dr. Elbert Goolsby, Paris, Texas, died of coronary occlusion November 23, 1946.

Born June 15, 1880, at Parks, Ark., Dr. Goolsby was the son of William Wade and Priscilla (Sullivan) Goolsby. He went to school in Quitman and Little Rock, Ark., and received his medical education at the University of Tennessee Medical Department, then at Nashville, being graduated in 1906. He later did postgraduate work in Chicago. His family had moved to Texas when Dr. Goolsby was still a boy, and he returned there to begin his medical practice. He was located at Direct for about ten years and then moved to Paris, where he was active until his death.

DR. ELBERT GOOLSBY

Dr. Goolsby had long been a member of the State Medical Association and American Medical Association through Lamar County Medical Society. In 1939 and again in 1945 he served the county organization as president. He was also a member of the Southern Medical Association. During World War II he was city and county health officer, and he was local surgeon for the Texas and Pacific and Santa Fe Railroads. He had been a member of St. Joseph's Hospital Staff for many years and was also on the Lamar Hospital board. He was a deacon and teacher of the men's Bible class in the First Baptist Church, was past president of the Lion's Club, a Mason, and a member of the Chamber of Commerce. In addition to his medical practice, Dr. Goolsby gave time to management of farm property and other real estate. He enjoyed fishing and golf in his leisure hours.

Survivors include Dr. Goolsby's wife, the former Miss Sallie Bryan, whom he married November 25, 1906, at Shop Spring, Tenn.; a daughter, Christine Goolsby, Paris; and two brothers, J. B. Goolsby and O. K. Goolsby, both of Idabel, Okla.

Dr. Henry G. Hertel, Giddings, Texas, died December 7, 1946, in a Brenham hospital of heart disease, with which he had been acutely ill about a week.

The son of Charles and Josephine (Wilderman) Hertel, Dr. Hertel was born August 9, 1874, near Freeburg, Ill. He first went to school in the Hertel School, situated at his birthplace, and later attended Central Wesleyan College, Warrenton, Mo., from which he received his bachelor of science degree in 1895. After teaching two years in the East Saint Louis High School, he entered Washington University Medical School, Saint Louis, and was graduated in 1901. He practiced in East Saint Louis until 1909, when he came to Texas. For eight years Dr. Hertel was engaged in the land and lumber business at Port O'Connor, but in 1917 he resumed the practice of medicine, first at Ledbetter, and then within a few months at Giddings, where he continued to practice until his death.

Throughout most of his career in Giddings Dr. Hertel was a member of the Lee County Medical Society, State Medical Association, and American Medical Association. He was president of the Lee County Society in 1930 and 1944 and was county health officer at the time of his death. He was president of the county school board, member of the

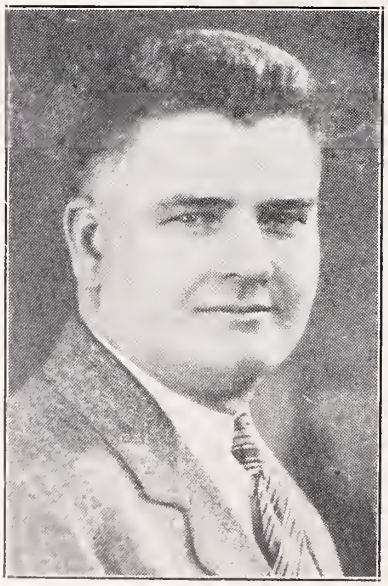
Lion's Club and of the Advisory Board for the city of Giddings, president of the Texas Highway 77 Association, chairman of the Lee County Highway Committee, director of civic improvement for the East Texas Chamber of Commerce, director and past president of Lee County Fair Association, member of Giddings Chamber of Commerce, and a member and past worshipful master of the Masonic lodge.

DR. H. G. HERTEL

Dr. Hertel is survived by his wife, Mrs. Lulu Hertel; a son, Charles Hertel, Granville, Ohio; a sister, Mrs. John J. Frick, Bay City; two brothers, Clarence Hertel, Corpus Christi, and Dr. G. E. Hertel, Austin, Minn.; and a grandson.

Dr. Edgar Wright Moss, for many years a physician of Collingsworth County, Texas, died December 7, 1946, at his home near Mission of coronary occlusion.

The son of John W. and Mary (Sanders) Moss, Dr. Moss was born January 27, 1882, at Lingleville, Erath County, Texas. He attended school at Lingleville and John Tarleton College, Stephenville. His medical education was received from Vanderbilt University, School of Medicine, Nashville, Tenn., and the old Southwestern University Medical College, Dallas, from which he was graduated in 1910. He interned at City Hospital, Dallas, and later pursued postgraduate studies at Tulane University, New Orleans, and Washington University, Saint Louis. In 1911 Dr. Moss went to Collingsworth County. He practiced for seven years at Quail, and then in 1919, after serving as a first lieutenant in the Army Medical Corps during World War I, he moved to Wellington, where he practiced the remainder of his active life. Ill health several years ago caused Dr. Moss to retire from practice, and he and Mrs. Moss had moved recently to make their home near Mission.



DR. E. W. MOSS

Throughout his professional life Dr. Moss was a member of the State Medical Association and American Medical Association, first through Dallas County Medical Society, then through Childress-Collingsworth-Donley-Hall Counties Medical Society, and after its organization Armstrong-Donley-Childress-Collingsworth-Hall Counties Medical Society. He was president of the county society in 1938 and 1944, and was elected to honorary membership in the State Medical Association in 1946. He was also a member of the Panhandle District Medical Society and the Southern Medical Association. He had been chairman of the section on obstetrics and gynecology of the Panhandle Society. He was a member of the Church of Christ and the American Legion.

On March 9, 1921, Dr. Moss married Miss Bess Carpenter, Wellington, who survives, as do two sisters, Mrs. Sim Price, Eastland, and Mrs. Stella Price, Lingleville; and three brothers, W. T. Moss and M. C. Moss, Lingleville, and J. M. Moss, Des Moines, N. M.

Dr. Holmes Ely Perrine, formerly of Fort Worth, Texas, died of tuberculosis in a Dallas hospital on November 22, 1946.

Dr. Perrine, son of Samuel E. and Katharyn Perrine, was born January 18, 1909, in Jamesburg, N. J. He attended Lawrenceville School, Lawrenceville, N. J., and Yale University, New Haven, Conn., from which he received a bachelor of arts degree in 1932. His medical degree was obtained at Temple University School of Medicine, Philadelphia, in 1936. He served an internship at Bridgeport General Hospital, Bridgeport, Conn., and a residency in neurology at Lenox Hill Hospital, New York. He was junior physician with the New Jersey State Hospital, Greystone, N. J., and the New York Hospital, Westchester Division, White Plains, N. Y. He also did work at the Graduate School of Medicine, University of Pennsylvania, Philadelphia. In 1942 Dr. Perrine began the practice of neurology and psychiatry in Fort Worth, but ill health forced him to give up his work in 1945.

DR. HOLMES E. PERRINE

While Dr. Perrine was in practice in Fort Worth he was a member of the Tarrant County Medical Society, State Medical Association, and American Medical Association. He conducted psychological examinations for military inductees of Tarrant and Dallas Counties during World War II. He was a Presbyterian and a Mason.

Dr. Perrine is survived by his mother, Mrs. Katharyn H. Coe, Fort Worth.

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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION AND PUBLIC HEALTH IN TEXAS

Guest Speakers for the Annual Session of the State Medical Association have all accepted their assignments on the scientific programs. As has been previously announced, the annual session will be held in Dallas, May 5-8, with headquarters at Hotel Adolphus. All general meetings, on which the out-of-state guests will appear, will be held at the headquarters hotel, in which scientific and technical exhibits and about half of the section programs will be housed. The other section programs and a few other activities of the Association will be held in the Baker Hotel, which will also be headquarters for the Woman's Auxiliary.

The honor guests, all of whom are outstanding in their respective fields, are as follows:

HONOR GUESTS

DR. HERBERT D. ADAMS, Boston (surgery).

DR. JOSEPH M. DONALD, Birmingham, Ala. (surgery).

DR. HAROLD O. JONES, Chicago, (obstetrics and gynecology).

DR. R. H. KAMPMEIER, Nashville, Tenn. (medicine).

DR. T. B. MAGATH, Rochester, Minn. (clinical pathology).

DR. WALDO E. NELSON, Philadelphia (pediatrics).

DR. WALTER L. PALMER, Chicago (medicine).

DR. JOHN J. SHEA, Memphis (eye, ear, nose, and throat).

DR. HARRISON H. SHOULDERS, Nashville, Tenn. (President, American Medical Association).

DR. WILSON G. SMILLIE, New York (public health).

DR. HARRY M. WEBER, Rochester, Minn. (radiology and physiotherapy).

As has been customary, each guest of a scientific section will deliver an address at a general meeting, speak more informally at a combined sections meeting, participate in a question and answer period at two clinical luncheons, and speak on the program of his host section. Dr. Shoulders, who comes to Dallas as guest of the State Medical Association as a whole, will appear at a general meeting.

Section officers have been busy since last summer making plans for informative and interesting papers by members of the Association. Most arrangements have been completed and well-rounded programs will be offered by the scientific sections.

The House of Delegates will convene, social functions will be held, and related special organizations will meet according to the general pattern which has been followed in previous annual sessions. Registration this year, however, is expected to exceed all previous records, partly because Dallas is a central location and partly because the cessation of war with its restrictions has made all physicians eager to meet for scientific stimulation and friendly recreation. While war has ceased, many of the difficulties of war remain. A scarcity of hotel accommodations is still to be taken into consideration.

While it is believed that Dallas hotels and tourist courts will be able to care for all physicians who attend the annual session, members of the Association are earnestly requested to make their reservations immediately so that they will be sure of accommodations. A list of hotels and tourist courts in Dallas, with rates, was published in the February number of the JOURNAL (page 568) for the convenience of those who plan to attend the annual session, and Dr. Jack

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G. Kerr, Medical Arts Building, Dallas, chairman of the Hotels Committee, will be glad to cooperate with those who need help in securing lodging.

The officers of the Association who have planned the 1947 annual session believe it will be one of the finest sessions yet held by the organization. They are eager to have as many members as possible participate in the activities which have been scheduled. They beg members to make final plans now to be present.

County Society Annual Reports will be due April 1, 1947. That means that the reports should be in the office of the State Secretary by that time, and that the membership of the State Association as of January 1, 1947, will be confined to those members listed in these reports. Any member who pays dues after the report of his county society has been filed with the State Secretary will show membership as of the time he actually paid, which may mean a lot and may mean it almost any time. Of course, there is a little leeway involved, in that the State Secretary cannot post all of the annual reports on April 1. For that reason, the State Secretary makes it a practice to add members to these reports as they pay belatedly, up to an upset time, depending upon circumstances. Therefore, the State Secretary urges that our members protect their memberships by paying dues at once, and certainly before April 1. If that is not done, the sooner they are paid, the better. In this connection, it should perhaps be said that any member of his county medical society for the last year can renew his membership for this year, provided he pays dues during the calendar year. After the expiration of the current year, a renewal of membership must be by re-application.

As of March 1, fourteen annual reports, with practically a 100 per cent membership, had been received in the office of the State Secretary. That really is some sort of a record.

As of March 1, our paid-up membership was 3,656, and that is one month before county society reports are due in the office of the State Secretary. On the same date in 1946, 2,282 members had paid dues.

It will be remembered that the State Medical Association has no members of its own. Members of county medical societies constitute its membership list. A member is identified at the annual session, when he comes to register his attendance thereon, by reference to his county society annual report. If his name is not written there, he cannot register. If his dues have not been paid to his county society secretary, and by him to the State Secretary, his name will not be there. The payment of dues of a member at the annual session Registration Desk, or anywhere else, at any time, must be made only by the secretary of his county society. The secretary may send the dues of a member by the member, but he should do so in writing. It is not sufficient that a member advise the State Secretary that the county society secretary has his money. The State Secretary must have it. And be it said in passing that the State Secretary did not set up the rule. Indeed, he was severely criticised at one time for permitting some members to register at the annual session under such circumstances.

Radio Programs Related to Medicine and Health are as near as your radio dial. Because the average person is interested in improving and maintaining his own health and finds the adventures of physicians and nurses full of excitement and drama, many advertisers have found programs pertaining to health and those who protect it to be financially worth sponsoring. Numerous such programs are now being broadcast. The programs to which the attention of our readers is called here, however, are those prepared and broadcast under the supervision of the medical profession.

Since 1944, Texas radio stations have been broadcasting fifteen-minute transcriptions on health subjects for lay listeners, prepared and distributed by the Bureau of Health Education of the American Medical Association, through county medical societies, with the cooperation of the State Medical Association. A total of sixteen Texas stations have participated in the broadcasts, and ten stations are now using the transcriptions. The programs are arranged in series, most of them planned for thirteen periods. Each series concerns a different subject. Some are primarily music, some are in lecture form, some are dramatizations, some are interviews; but all contain health information attractive to the lay person.

The transcriptions are available upon request by county medical societies, through the State Medical Association, or may be obtained direct from the Bureau of Health Education of the American Medical Association. They may be used as sustaining features by radio stations or they may be sponsored by local firms approved by county medical societies.

Stations in Texas currently broadcasting the health transcriptions, most of them weekly, include the following: KRIC, Beaumont; KRLD, Dallas; KFJZ, Fort Worth; KORC, Mineral Mells; KNET, Palestine;

and KIUN, Pecos, on a sustaining basis, and KBWD, Brownwood; KTSM, El Paso; KVOP, Plainview; and KGKB, Tyler, with sponsors, all of which happen to be drug stores.

Another radio program now being broadcast under sponsorship of the American Medical Association and the Mutual Broadcasting System is called "Dr. Graham and Family." Most of the twenty-six stations in Texas affiliated with the Mutual system are broadcasting this dramatic series each Monday night at 9:30 o'clock. A thirty-minute dramatization originating in New York City, "Dr. Graham and Family" is the story of the life of a general practitioner in a medium size, typical American community. The program is interpretative rather than educational, but the glimpses of medicine which show through the drama of the physician in his home life, his practice, and his community relationships are modern and informative.

Perhaps of greatest interest to the physician listener is a series of broadcasts commemorating the one hundredth anniversary of the establishment of the American Medical Association. The National Broadcasting Company in cooperation with the American Medical Association is broadcasting a thirty-minute program each Saturday afternoon at 3 o'clock, Central Standard Time, designed to show the progress of medicine since 1847. Before "Doctors—Then and Now" has been concluded, each region of the United States will be given an opportunity to tell something of its medical history. Each program consists of a dramatization portraying a physician prominent in the early history of the featured region and of a short talk describing the present status of medicine in the region. The dramatization originates in a Chicago studio, but the talk is delivered by a physician from the region and originates in a local studio. The programs are designed for the general public, but from them the physician listener can learn much of the heroic struggle medicine has had during the preceding century and of its present stage of development throughout the nation.

Texas listeners will be particularly interested in the program on Saturday afternoon, April 26, in which their own state will be honored. A dramatization of the life of Dr. Anson Jones, a practicing physician and an active statesman in the days when Texas was a republic, and a talk by Dr. Elliott Mendenhall, a Dallas physician prominent in Texas medicine today, will be heard on that date.

Members of the State Medical Association of Texas are urged to promote radio programs dealing in an authentic manner with health, medicine, and the medical profession. There can be no question of the reliability of programs not only approved, but actually prepared by the American Medical Association. Physicians should listen to such programs themselves and should recommend them to their patients. Physicians may also be of service in encouraging their local radio stations to broadcast one or more of the programs described in these columns. The programs have already proved their popularity, but they can be even more valuable in disseminating health facts and medical good will if doctors of medicine generally will underwrite their success.

The Centennial Session of the American Medical Association will be held in Atlantic City, N. J., June 9-13. This session, celebrating the one hundredth anniversary of an organization which has meant much in the life of the United States, is being planned with care and promises to be the most outstanding meeting which American physicians have ever held.

Even before the session officially opens, activities will begin. On June 7 the Board of Trustees and officers of the Association will entertain leaders in the various industries and occupations associated with medicine at a banquet at which distinguished speakers will comment on the influence of medicine on the nation's progress. The following day, Sunday, June 8, a religious service will be held in the great hall in Atlantic City, with leaders of the Catholic, Protestant, and Jewish faiths as speakers. It is hoped that ministers throughout the nation will observe that Sunday by delivering sermons on the spiritual aspects of medicine and health.

Also scheduled for Sunday, June 8, is a national conference of county society officers. Called by the Board of Trustees of the American Medical Association following introduction in the December, 1946, session of the House of Delegates of a resolution favoring such a conference, the meeting is "to bring attention to the problems of various localities and to promote exchange of information on voluntary health insurance plans, hospitalization plans, and improvement in medical facilities, rural health activities, and activities of the various bureaus and councils of the A. M. A." The attention of county society officers is directed to this conference, the first of its kind to be held in conjunction with an annual session of the American Medical Association.

The House of Delegates will convene on Monday, June 9, in the Traymore Hotel,

while the scientific program and technical and scientific exhibits will open in the Convention Hall. A special exhibit depicting the progress of scientific medicine will be set up along the board walk and made available to the public. Motion pictures especially developed for the occasion will be shown. The evolution of the scientific motion picture, a picture especially prepared by the March of Time, and other new films will be featured.

Eminent physicians and scientists from throughout the world have been invited to participate in the centennial session. Each scientific section will have as its special guest a physician from a foreign country, who will also appear on a general program. Each scientific section will also hear a speaker describe the development of its field throughout the last hundred years.

A dinner for the House of Delegates and officers and members of councils of the Association will be given by the Board of Trustees on Monday night, June 9. The following night, the President will be installed and two musical artists of high repute will appear on the installation program. Wednesday night, June 11, has been reserved for the President of the United States, subject to his acceptance. The final night, June 12, will be devoted to the Ball for the President of the Association.

With such a splendid scientific program, such outstanding speakers, such interesting exhibits, and such fine entertainment, more physicians than ever before will be present for the meeting of the Association this year. It is therefore highly important that those who expect to attend make definite arrangements now. Transportation facilities may be crowded, but railways and other public carriers have already announced special accommodations for those who reserve space early. Hotels in Atlantic City will certainly be crowded, but the Subcommittee on Hotels, Dr. Robert A. Bradley, Chairman, 16 Central Pier, Atlantic City, will do its best to make satisfactory arrangements for physicians who send in their reservations immediately.

The American Medical Association, old and mellow because of the hundred years of history behind it, but young and vigorous as it anticipates a brilliant future, will stage an unforgettable celebration next June. Only those physicians who now make their reservations certain will be sure of being present to help celebrate.

Only Fellows of the American Medical Association may register at the meeting, but any member of a state medical association may become a Fellow and receive a year's subscription to *The Journal of the American Medical Association*, the greatest medical journal in the world, by proving his membership and paying the sum of $8, the cost of THE JOURNAL alone to those who are not Fellows.

The State Legislature and Our Legislative Program.—It is most difficult to keep our readers informed as to the progress in the State Legislature of our legislative program. The exigencies of publication and legislative progress will not permit. Our Legislative Committee and our Committee on Public Relations, not to mention other agencies of the State Medical Association, have been busy, and have had the situation at Austin well in hand from the beginning. The members of the State Medical Association have been unusually active in contacting their Legislators, considering their preoccupation in the practice of medicine. At that, Legislators have received and are receiving communications, in person, by mail, and in every other way, from the multitude. The unwary Legislator might consider such disproportion in petition as significant, and it is significant. However, such petitioning in such a cause is usually artificial, and worked up by active campaign committees. The medical profession would protect the public health by so regulating the standards of the practice of the healing arts that those who assume the serious responsibilities of treating the sick, by whatsoever method, are sufficiently informed in the basic sciences to know what they are about. There are those practicing the healing arts now who fear that any such standardization will curtail their activities and, as some of them have expressed it, "put them out of business." It is not easy for the average layman to get the difference and certainly not where he is being persuaded by partisans. It is sufficient to say in this connection, that practitioners of scientific medicine, the sort of medicine which knows no limitation, should persist in their endeavors to make Legislators understand that they are in earnest in this matter of protecting the public against ignorance and quackery in the sick room. Their Legislators want to hear from them, provided their communications are genuine and representative. We do not think legislators want to be pestered with a multitude of meaningless and pointless communications. The plea of the opponents of our medical licensure legislation is specious, and more often than otherwise based on misapprehension and misinformation. This is true to the point of absurdity, which is one reason why doctors so seriously dislike to engage in political and legislative activities.

Just before we go to press, the status of the legislative program is about as follows:

The Basic Science Bill, S. B. 35, by Senators Walter Tynan, George Moffett, Buster Brown and Gus Strauss, and H. B. 217, by Representatives Jack F. Ridgeway, Phillip L. Willis, Sidney McClain, A. J. Overton, Jr., O. E. Latimer, and Eugene C. Williams. The Senate Bill has been reported out of committee, with the recommendation that it pass. It should come up in the regular order of business before the end of the month. The House Bill is still in the hands of the committee. It is upon this measure that our Legislative Committee, under the direction of our House of Delegates, has pitched our campaign for a revision of the medical licensure laws. There is, or should be, no differences between practitioners of the healing arts in the matter of any of the basic sciences. Science knows no limitations.

The practice acts governing the methods of practice must be in accord with the teachings of the school, sect, or group of practitioners to which they relate. They do not apply anywhere else. The Basic Science Board of Examiners will differ fundamentally from the boards of examiners of the various branches of the healing arts, in that personnel of such a board will have no concern as to the method of practice any examinee proposes to follow. No member of this board will be engaged in the active practice of the healing art. They will be persons of education engaged in teaching the several sciences concerned, and not with the application of these sciences to any method of practice. Nothing could be fairer than that and no procedure designed to encompass the entire field could be more protective of the interest of the public health.

A rather strange situation has developed in connection with this bill. The osteopaths insist upon it that the bill lowers the standard of the practice of medicine, while the chiropractors and the naturopaths contend that the bill raises the standards of practice unduly by imposing upon them scientific subjects which do not apply to their respective methods of practice. The answer is, of course, that each branch of the healing art, in preparing its own practice act, shall apply the standards set up by the Basic Science Bill in accordance with the needs of its own group.

The Chiropractic Bill, S. B. 79, introduced in the Senate by Senators Pat Bullock and Fred R. Harris, and H. B. 40, introduced in the House by Representatives Henry G. Lehman and F. G. Swanson, has been favorably reported by the committee in both branches of the Legislature. It occupies very favorable position on the calendar. Our friends in the Legislature insist that the Chiropractic Bill should not become a law before the Basic Science Bill is enacted. No practice act, regardless of school or sect or branch, should be passed until there is a basic science law. Incidentally, the effort now is to place chiropractors in the category of dentists or optometrists, clearly an evasion and certain to be declared unconstitutional unless the Basic Science Bill becomes a law. The attempt to compare dentists and optometrists with chiropractors is rather ridiculous on the face of it. Nobody treats the spine for the sake of the spine itself. Treatment accorded the spine is for the purpose of healing the sick.

The Naturopathic Bills, of which there are three in each branch of the Legislature, two exemptions and the other a practice act, are trailing. The Senate bills, S. B. 59 and S. B. 154, both introduced by Senator Charles R. Jones, are still in committee, but the House bills, H. B. 86 and H. B. 160, introduced by Representative Fred J. Jones, have been favorably reported by the committee in the House, and are on the House calendar. S. B. 190, by Senator Charles R. Jones, and H. B. 344, by Representative Fred J. Jones, are identical measures, are referred to as Physiotherapy Bills, and provide exemption from the Medical Practice Act. Like the Chiropractic Bill, these bills should be held back until the Basic Science Bill has been enacted into law. Without something of the sort, as in the case of the chiropractic measure, they will not be constitutional.

Our friends in the Legislature will not oppose the passage of either the Chiropractic or Naturopath Bill if the passage of the Basic Science Bill is assured, except and unless they, or either of them, contain provisions which would nullify important parts of the Basic Science Bill, or of the Enabling Act for the unlimited practice of medicine, the Medical Practice Act of Texas.

The Revised Medical Practice Act Bill was introduced in the Senate by Senator Walter Tynan. It is S. B. 115. This measure has not been introduced in the House. It represents the present Medical Practice Act as amended in the light of the proposed Basic Science Law. The subjects included in the Basic Science Bill are omitted from the Medical Practice Act, and subjects pertaining to the art of the practice of medicine and extension of some of the scientific subjects have been incorporated. It so happens that should the Basic Science Bill pass and the Revised Medical Practice Act not pass, no harm will be done except to the extent that there will be a duplication of the examination, at least to some extent, in the so-called basic sciences. However, neither this bill nor

any other of the practice act bills should be enacted into law until the passage of the Basic Science Bill is assured, for the principal reason that if such should happen, examination in the basic sciences of those who would practice medicine would be thus abandoned. It is certain that should the Basic Science Bill and the Revised Medical Practice Act Bill both become laws, the standards of the practice of medicine will be elevated in this state, and in no instance will any person who is licensed to practice any of the healing arts at the present time be required to take the basic science or any other examination. The right to practice medicine cannot be taken away from anybody except through courts, and there must be good reasons for doing it there. It is in this connection that one of the difficulties of the new medical licensure plan is encountered. Neither the chiropractors nor the naturopaths have heretofore been licensed to practice medicine in Texas. They therefore find it difficult to set up the so-called "grandfather clause," under which those who have been practicing may be exempted from the application of either the Basic Science Law or a practice act. The osteopaths, who are now licensed to practice medicine without limitation, will continue in that practice, and the osteopaths themselves will fix the terms of their own practice act.

The Coroner's Autopsy Bill was introduced in the House by Representative Woodrow W. Bean and in the Senate by Senator Buster Brown. It is known in the House as H. B. 217 and in the Senate as S. B. 161. The House committee has reported the bill favorably, and it has taken its place on the House calendar. There has been no adverse criticism of this bill, at least so far as we know, and the authors of the measure are confident that it will be passed, provided it does not get entangled in legislative red tape to the point of strangulation. It will be recalled that this measure has been worked up by the pathologists of the state, but with the consent and help of the State Medical Association, and has been made one of the must items on our legislative program. The bill is intended to correct a very serious discrepancy in the service of the coroner, and to relieve doctors who must perform autopsies under the law, and the hospitals, from some of the inhibiting jeopardies that heretofore have been found to exist. It is most important legislation, from the standpoint of both the medical profession and the lay public.

The Hospital Construction Bill, H. B. 503, was introduced in the House by Representative Grady Moore of Red River County. This is a measure set up by the Hospital Commission appointed by the Governor some months ago to conduct a survey of the hospital situation in the state, anticipatory to the enactment of the Hill-Burton Bill in Congress. It seems that the work has been carried on under the direction of the State Board of Health and this commission, upon which commission, incidentally, the Hospital Association and the State Medical Association are both represented. The bill has not been studied by our Legislative Committee, but we are informed by the representatives of the Texas State Hospital Association that it is purely routine and seems to be called for by federal agencies in charge of the administration of the Hill-Burton Act.

The Hospital Licensing Bill, S. B. 29, was introduced by Senator G. C. Morris. The bill has been referred to a subcommittee of the Senate committee. This bill is sponsored by the Texas State Hospital Association. The purpose of the measure is to bring about a standardization of hospitals throughout the state as relates to safety and efficiency, and to lay the predicate for participation in the hospital construction funds to be distributed by the federal government. No money will go to a state for any such purpose except and until there is a satisfactory licensing bill pertaining to hospitals. The Legislative Committee of the State Medical Association, in conference with interested groups, has given this bill very thorough study. After securing a number of amendments deemed advisable, if not necessary, the bill was given the green light by our committee. The hospital people advise that the bill supplements the hospital construction bill, even though they are both designed to facilitate the use of federal money in the construction of hospitals and the extension of hospital service in the state.

Additional Tuberculosis Service by the state is provided in S. B. 147, introduced in the Senate by Senator A. M. Aikin. The same bill was introduced in the House by Mrs. Neveille H. Colson. It is H. B. 311.

This measure is sponsored by the Texas State Tuberculosis Association, and has been approved by the Legislative Committee of the State Medical Association. It carries an appropriation of $1,600,000 with which to construct additional hospitals in two sections of the state where tuberculosis is particularly prevalent. There is no controversy as relates to this measure, except, as a matter of course, in connection with any expenditure of state funds. It is believed that there will be no determined opposition to the bill. It should pass.

A Cancer and Pellagra Hospital will be constructed near Dallas if H. B. 237 by Rep-

resentative George Parkhouse, et al, becomes a law. Such an institution has already been provided for by law, but there never has been an appropriation for its construction. It is felt that the institution is badly needed, at least for the study of cancer, and the Legislative Committee of the State Medical Association has approved the idea. It may be recalled that the State Medical Association had much to do with the passage of the original measure, which resulted, incidentally, in the construction of a Psychiatric Hospital at Galveston, in connection with the Medical Branch of the University of Texas. The original idea was to provide such an institution, plus the pellagra and cancer facilities, near the then only two medical colleges in the state. It was expected that the medical colleges would furnish the medical staffs for the institutions, and that the patients would be useful in teaching the subjects concerned.

There are numerous other measures of a medical and public health sort. They are being studied by our Legislative Committee, and action will be taken in due time in each instance. We are not in a position to discuss these measures now.

Questionnaires to Physicians in Civilian Practice during World War II were mailed recently by the Committee on National Emergency Service of the American Medical Association in an effort to complete a study of how the medical profession can best serve the population, civilian and military, in the event of a future national emergency. As only 5,000 such questionnaires have been distributed, it is important that each physician receiving a form fills it out as completely and accurately as possible and returns it to the committee.

On the basis of the answers to the questionnaires, it is hoped that facts may be determined as to how the civilian population was served during the recent war. Space will also be provided for physicians receiving the questionnaires to suggest changes which should be made in the mobilization of medical service in future emergencies. These facts and suggestions, together with data secured from a questionnaire mailed last December to 50,616 former medical officers, will serve as a basis for recommendations to be made by the committee to the House of Delegates of the American Medical Association in June.

The Committee on National Emergency Service reports that excellent response was secured from the former medical officers to whom questionnaires were sent. If each physician who cared for civilians during the war and who receives a questionnaire will consider it his duty to coöperate in the study, the over-all accuracy of facts obtained and the soundness of conclusions reached will be immeasurably increased.

The Library Building Fund continues to grow. Cass-Marion Counties Medical Society has recently contributed $24 to the County Medical Society Library Building Fund, a donation which is highly appreciated.

The Kerr-Kendall-Gillespie-Bandera Counties Woman's Auxiliary has contributed a $25 United States Savings Bond, Series F, to the same fund. The contribution was in memory of Dr. John Dee Jackson of Kerrville, recently deceased.

The Kerr-Kendall-Gillespie-Bandera Counties Medical Society has contributed $215 to the Library fund, also in memory of Dr. Jackson.

Dr. Jim Camp of Pecos, has donated, through the Woman's Auxiliary, to the Library fund the sum of $10 in memory of Dr. W. H. Moore of Fort Stockton, recently deceased.

Miss Harriet Cunningham, assistant to Dr. R. B. Anderson, Jr., has contributed the sum of $25 to the Library Building Fund, in memory of Dr. Anderson, recently deceased.

Those who contribute toward the fund to provide a new Library building for the Association naturally look forward to the future with a Library adequately housed and services enlarged. It is not amiss, however, to call attention to what is available in the present Library, for its facilities already offer unusual opportunities.

A service in which our librarians, upon request, prepare individually selected material consisting of reprints, journals, and books of information on any phase of a given subject has proved highly beneficial to physicians throughout the state for a number of years, yet many of our readers still do not know that 25 cents to help cover postage and the expense of collecting material will promptly bring them information on almost any medical subject. All that is needed is that their requirements be made known.

A second service which has been more recently developed by the Library of the State Medical Association is that of circulating medical motion pictures, some designed for professional audiences and some for lay groups. Films suitable for county medical society programs, nurse's training courses, women's auxiliary meetings, and parent-teacher association activities are available on loan for merely the cost of shipment.

Members of the State Medical Association are encouraged to keep one eye on the present Library, making frequent use of its

facilities, and the other eye on the future Library, remembering that enthusiasm for a better Library and the contribution of adequate funds for its development will assure the success of the project, which is maintained solely in the interest of Texas physicians and the public health.

CURRENT EDITORIAL COMMENT*

Congenital Anomalies Following Maternal Rubella.—Attention has recently been focused on a series of congenital anomalies found in infants born to mothers who have had rubella during the early part of their pregnancies. The original reports made their appearance in the Australian literature in 1941, but more recently a number of articles have appeared in the American medical literature and even a comment in a well known national weekly magazine. During the past six months I have seen two children, each approximately 2 years old, whose mothers gave histories of having had rubella during the first trimester of pregnancy. Both of these children showed evidence of the type of congenital anomalies which will be described. In recent surveys, an attempt has been made to determine the possibility that other virus diseases during pregnancy may cause similar conditions. However, with very few exceptions, the mothers of these congenitally defective infants suffered from an exanthematous disease diagnosed as rubella during the early stages of pregnancy. Gregg's original article was published following an epidemic of rubella in Australia in 1940. He was impressed with the severe toxic reactions that occurred in the mothers during this epidemic and advanced these reactions as a possible factor in the development of anomalies in the offspring. However, no such toxicity has been observed in the cases seen in this country; in fact, the disease was exceptionally mild in many instances.

The types of congenital defects associated with this condition have been relatively constant, affecting chiefly the eyes and heart. Congenital cataracts, either unilateral or bilateral, have been the most constantly found defects. Next in frequency have been various forms of congenital heart disease. The most frequent cardiac anomalies reported were a widely patent ductus arteriosus and a patent foramen ovale. It has been pointed out that the most important period for the development of congenital defects of the heart is from the fifth to the eighth week of intrauterine life, during the period when the septa are being formed. This is precisely the same time during which the mothers of the defective infants suffered from rubella. Another frequent defect is mental deficiency, which is usually found in addition to the previously mentioned anomalies. Other less frequently encountered anomalies reported in this group include deaf-mutism, microcephalus, hypospadias, and cleft palate. In most instances, the pediatrician is impressed very early with the malnourished appearance of the infant at the time of birth and with the inevitable feeding problem and lack of normal development that follows.

The mechanism leading to the production of these anomalies is unknown. Several theories have been suggested, but to date all are founded on pure speculation. Why reports of these anomalies have only recently begun to appear in the literature calls for comment. It has been suggested that perhaps the virulence of the virus of rubella has undergone some change in the past few years, thus accounting for these recent reports. This is unlikely, the more logical explanation being that it remained for a keen observer to associate cause and effect. Just how our present knowledge of the effect of rubella in early pregnanacy will affect the future management of pregnancies so complicated is difficult to conjecture. Some have gone so far as to advocate interruption of pregnancy in proven cases of rubella complicating early pregnancy. However, this procedure is hardly justified in the light of our present understanding of the subject. Exposure of as many pre-adolescent girls to rubella as possible offers a solution; however, the difficulties involved in mass controlled exposure are obvious. Future management will depend to a large extent on knowledge gained from additional contributions to the literature.

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*This department of the JOURNAL presents editorial comments on current items pertaining to the science, art and practice of medicine, contributed by members of the State Medical Association and scientists closely associated with the medical profession of Texas. Invitation is hereby extended to any member of the State Medical Association of Texas to submit such discussions for this department. The discussions should not be more than 500 words in length.

COUNCIL TO TEST COSMETICS

Two new divisions, cosmetics and toxicology, are being formed under the Council on Pharmacy and Chemistry of the American Medical Association. The Council announces that the division on cosmetics will find out what irritating substances are used in cosmetics, cold wave lotions, creams, and fatty emollients, and what effect they have over long-time usage. The division on toxicology will investigate and report effectiveness and dangers of cleaning agents, insecticides, and rodenticides. Report of the findings will be for information of the medical profession and the public.

PRESENT STATUS OF KNOWLEDGE CONCERNING ETIOLOGY OF PRIMARY ATYPICAL PNEUMONIA

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The name "virus pneumonia" has been applied rather loosely to the increasing number of cases of acute respiratory infection associated with atypical pulmonary lesions in which the common pathogenic bacteria do not seem to play an etiologic role. This name has come to be widely used by the practitioner and frequently is employed merely because of failure to append a pathogenic micro-organism as the causative agent. These cases are now separated from other pneumonias and are generally designated "primary atypical pneumonia, etiology unknown." This name, recently recommended to the Surgeon General for use in the United States Army, is perhaps the most suitable designation for this fairly well-defined clinical syndrome and implies that an effort has been made to rule out the known bacterial and nonbacterial agents.

There is still considerable doubt as to whether or not atypical pneumonia is a new disease. It appears certain that similar cases have been noted from time to time in various parts of the world during the past ten years. Only since the beginning of the war, however, have frequent reports drawn attention to its prevalence. It is likely that the apparent rise in incidence is due to the increased opportunities for infective spread provided by wartime conditions.

Primary atypical pneumonia may be produced by a variety of agents including bacteria, fungi, rickettsia, and viruses. Recent studies have indicated that while the lymphogranuloma-psittacosis group of viruses may be the cause of many cases of primary atypical pneumonia, the great majority are probably not caused by these agents.[28] It seems likely, then, that the bacteria, fungi, rickettsia, and the members of the lymphogranuloma-psittacosis group of agents, taken together, account for only a small proportion of the total number of cases diagnosed as primary atypical pneumonia. The agent or agents responsible for the majority of cases have not as yet been discovered.

Extensive investigations have been carried out in an attempt to transmit this disease. Stokes, Kenney, and Shaw[31] reported transmission of a pneumotropic agent from throat washings of patients with atypical pneumonia to ferrets and mice. Unfortunately, the agent was lost after several passages in mice, and its serologic relationship to the patient's illness was not established. Weir and Horsfall[33] recovered a virus causing pneumonia in the mongoose from patients with acute pneumonitis, and later Johnson[15] produced pulmonary lesions in cotton rats by intranasal inoculations with sputa from cases of atypical pneumonia. Eaton and his associates[7, 8] also produced lesions in cotton rats and hamsters inoculated with sputa and lung tissue from patients with atypical pneumonia. Most consistent results, however, were obtained by the inoculation of chick embryos. Also, the agent could be neutralized by convalescent sera from patients with the disease. Horsfall and his associates[13] likewise obtained lesions by direct intranasal inoculation of cotton rats with sputa from certain cases of atypical pneumonia, but the agent was not maintained on passage. The virus isolated was related to the mongoose virus of Weir and Horsfall[33] and to the pneumonia virus of mice recovered by Horsfall and Hahn.[14] Rose and Molloy[26] reported the appearance of pulmonary lesions in newly weaned guinea pigs inoculated intranasally with specimens from patients ill with atypical pneumonia. Sanders[27] isolated a virus in tissue culture and in mice from the sputum of a patient with atypical pneumonia. Dingle and his associates[5] later suggested that this virus, which produces fatal encephalitis in mice but fails to cause pulmonary lesions, is a variant of the herpes virus. These and similar studies in which the relationship of the virus isolated to the human disease has

TABLE 1.—*Viruses Recovered from Cases of Primary Atypical Pneumonia, Relationship to Human Disease Not Fully Established.*

Source of Material	Experimental Animal	Investigators
Throat washings and blood from cases of Reimann	Mice, guinea pigs, ferrets	Stokes et al.[31] Francis and Magill[10]
Throat washings	Mongooses	Weir and Horsfall[33]
Sputum, lung tissue	Cotton rats	Eaton et al.[8]
Postmortem blood, brain, lung tissue	Guinea pigs, mice*	Smadel et al.[29]
Throat washings, sputum, plasma	Cotton rats	Horsfall et al.[13]
Throat washings, sputum	Cotton rats	Johnson[15]
Sputum, throat washings, blood, lung, spleen	Recently weaned guinea pigs	Rose and Molloy[26]
Sputum, long tissue	Chick embryos	Eaton et al.[7]
Sputum	Tissue culture, mice	Sanders[27]

*Virus of lymphocytic choriomeningitis recovered.

From the Department of Bacteriology and Immunology and Virus Research Laboratory, Southwestern Medical College.
Read before the Section on Medicine, State Medical Association of Texas, Annual Session, Galveston, May 7, 1946.

not been fully established are summarized in table 1.

A number of agents related to the lymphogranuloma-psittacosis group* of viruses have been recovered from cases of primary atypical pneumonia. Francis and Magill[10] isolated the so-called "meningopneumonitis" virus in mice, ferrets, and monkeys from throat washings of patients with the disease. Subsequently, Eaton and his coworkers[6] recovered a similar agent. Late in the nineteenth century Ritter[25] observed psittacosis as a pneumonic infection occurring after contact with tropical birds. Since that time the disease has become increasingly recognized, and sporadic outbreaks have been reported in various countries. Human infection has been traced to parrots, parakeets, finches, arctic fulmar, doves, and chickens, and in 1941 Meyer[18] first incriminated the pigeon. He isolated a virus similar to that of psittacosis from the lung of a patient who had a history of exposure to a flock of racing pigeons. A virus, indistinguishable from that recovered from the patient, was also isolated from some of the pigeons. At about this time Meyer and his associates[21] suggested that the term "psittacosis" be reserved for those cases of human infection occurring after contact with psittacine birds such as parrots, parakeets, love birds, and canaries, and that the term "ornithosis" be applied to infection following exposure to doves, pigeons, chickens, and the like. In 1942, Meyer[19] reported that 10 cases of human atypical pneumonia with 2 deaths could be traced to exposure to different species of pigeons, these cases being distributed among several states. Favour[9] also reported 3 cases of ornithosis confirmed by means of the complement-fixation test. A history of contact with pigeons was obtained in 1 case and with a sick canary in the second. There was no history of any direct contact in the third. Smadel[28] studied 45 cases of sporadic atypical pneumonia occurring among large eastern urban populations. He was able to make a definite diagnosis in 10 instances by means of the complement-fixation test. Six of these patients gave a history of contact with pigeons. He concluded that one-fourth of the sporadic cases of atypical pneumonia were due to infection with the virus of psittacosis (ornithosis). Recently, Meiklejohn and his associates[17] reported 10 cases of ornithosis which they had collected over a four year period. In all of these cases the diagnosis was confirmed by isolation of the virus and through serologic means. Four of their cases were naturally occurring with a history of pigeon contact, 3 were in nurses who had contracted the virus from infected patients, and the last 3 were laboratory infections. Four of these cases were very severe and had a fatal termination.

TABLE 2.—*Viruses Recovered from Cases of Primary Atypical Pneumonia Related to the Lymphogranuloma-Psittacosis Group.*

Source of Material	Results	Investigators
Throat washings	"Meningopneumonitis" virus isolated in mice, ferrets, monkeys	Francis and Magill[10]
Throat washings, sputum blood, lung, liver, spleen	Virus related to agent isolated by Francis and Magill[10]	Eaton et al.[6]
Lung tissue, sputum	Pigeon virus isolated*	Meyer[18] Meyer et al.[21]
Sputum	Virus isolated in mice	Stickney and Heilman[30]
Sputum, throat washings, lung tissue	Virus recovered from 2 patients	Smadel[28]
Sputum	Virus of pigeon ornithosis isolated	Meiklejohn et al.[17]
Sputum	Related to virus isolated by Francis and Magill[10]	
Sputum, lung, spleen	Related to virus of Eaton et al.[6]	
Throat washings, sputum, blood, tissue suspensions	Virus isolated in mice, guinea pigs	Larson and Olson[16]

*A virus indistinguishable from that of the patient was isolated from the spleen and liver of pigeons with which the patient had contact.

A recent outbreak of severe pneumonitis in Louisiana[16] is of interest because of the finding of a new virus transmissible to animals and apparently spread by contact with infected patients. The epidemic occurred in six isolated communities in the bayou region of Louisiana. A virus was obtained from throat washings in 3 of the 4 cases that were tested, and in 2 fatal cases it was also isolated from autopsy material. It was propagated in white mice by either intraperitoneal or intranasal inoculation and in guinea pigs by intraperitoneal inoculation using either the throat washings or tissue suspensions. The symptoms and gross lesions in animals were similar to those observed with the psittacosis group of viruses, and there were readily demonstrable elementary bodies in stained smears of the spleen, liver, and lungs of the infected animals. The various studies in which viruses related to the lymphogranuloma-psittacosis group were recovered from cases of primary atypical pneumonia are summarized in table 2.

The results of animal experimentation are frequently difficult to interpret because of the occurrence of spontaneous disease caus-

*Included in this group are the viruses of psittacosis (ornithosis), lymphogranuloma venereum, trachoma, inclusion blennorrhea, human pneumonitis,[6] meningopneumonitis,[10] mouse pneumonitis,[22] and feline pneumonitis.[1, 11] These agents are remarkably alike in that they possess similar developmental forms, tinctorial characteristics, and closely related antigenic components as revealed by the complement-fixation test.[6] Hilleman[12] recently studied the immunologic relationship between these viral agents by means of potent neutralizing antiserums prepared in chickens and even suggested the possibility of using chicken antiserums for the treatment of cases of human infection.

ing pulmonary lesions in the animals employed. For example, Horsfall and Hahn[14] isolated a filtrable agent from the lung tissue of apparently healthy mice. This agent seems to differ from other viruses known to occur in normal mice. An antigenically related virus was isolated by Pearson and Eaton[23] from the lung tissue of Syrian hamsters. Also, an agent unlike that recovered by Horsfall and Hahn[14] but related to the lymphogranuloma-psittacosis group was recovered by Nigg[22] from the lung tissue of apparently normal mice. Pinkerton and Swank[24] isolated an agent related to the lymphogranuloma - psittacosis group from pigeons on a thiamine-deficient diet. This agent, which was subsequently lost, was similar to the meningopneumonitis virus of Francis and Magill.[10] Baker isolated an agent from feline pneumonia and suggested its causal relationship to human atypical pneumonia. This agent subsequently proved to be a virus of the lymphogranuloma-psittacosis group.[1] Blake, Howard, and Tatlock[2] isolated a pneumotropic agent from cats ill concomitantly with human cases of atypical pneumonia in a household. Their studies suggested that atypical pneumonia in 4 members of the family which owned this cat may have been caused by the same virus. Incidentally, this is not the same virus. Incidentally, this is not the same as the feline pneumonia virus isolated by Baker. Meyer and Eddie[20] isolated a virus related to the lymphogranuloma-psittacosis group from the spleen, liver, and kidney tissue of chickens and suggested its relationship to the human infection. Some of these studies are summarized in table 3.

TABLE 3.—*Viruses Probably Related Etiologically to Primary Atypical Pneumonia Isolated from Extra-Human Hosts.*

Source of Material	Experimental Animal	Comments	Investigators
Lung tissues from apparently healthy mice	Mice	Differs from other viruses known to occur in normal mice	Horsfall and Hahn[14]
Lung tissue from Syrian hamsters	Hamsters, mice	Antigenically related to mouse-pneumonitis virus of Horsfall and Hahn[14]	Pearson and Eaton[23]
Lung tissue from apparently normal mice	Mice	Not same as virus of Horsfall and Hahn[14]	Nigg[22]
From pigeons on thiamine-deficient diet	Mice	Agent subsequently lost*	Pinkerton and Swank[24]
Spleen, liver, kidney tissue from chickens	Mice	See footnote*	Meyer and Eddie[20]
Lung tissue from cats ill with pneumonia	Mice, chick embryos	See footnotes*†	Baker[1]
Lung tissue from sick cat	Cats	Not same as feline pneumonia virus isolated by Baker	Blake et al.[2]

*Related to lymphogranuloma-psittacosis group.
†Hamre and Rake[11] distinguish this agent from other members of this group by means of its tropisms, lack of susceptibility to sulfonamides, and specificity of its toxin.

There is evidence, therefore, that a group of viruses, some related to the viruses of psittacosis and lymphogranuloma venereum, are capable of causing respiratory infections and pneumonia in man. Also, it is evident that extra-human hosts including pigeons and barnyard fowls may carry such viruses. The frequency and importance of human infection with these agents have not yet been fully shown, probably because of the lack of a uniformly susceptible animal host. No adequately confirmed studies have described the isolation in the experimental animal of an agent clearly related immunologically to the human disease. Hence, the identity of the infectious agent and the mode of transmission must be considered unknown.

Studies which have been undertaken to obtain information concerning the transmissibility of the disease in the natural host are summarized in table 4. Vance, Scott, and Mason[32] were unsuccessful in their attempt to transmit the disease to 7 volunteers by intranasal inoculation with filtrates of pooled nasal washings and sputa. Recently, the members of the Commission on Acute Respiratory Diseases of the United States Army[4] reported the results of a series of experiments in human volunteers inoculated with respiratory tract secretions of patients ill with this disease. Mild, primary atypical pneumonia

TABLE 4.—*Attempts To Transmit Primary Atypical Pneumonia To Human Beings.*

Source of Material	Results	Investigators
Filtered pooled sputum, nasal washings	Negative results in 5 human volunteers	Vance, Scott, and Mason[32]
Unfiltered pooled sputum, throat washings	Mild primary atypical pneumonia and minor respiratory illness in 10 of 12 subjects*	Commission on Acute Respiratory Diseases[4]
Pooled throat washings, sputum; filtered and unfiltered	3 of 12 persons receiving filtered specimens and 3 of 12 receiving unfiltered material developed primary atypical pneumonia; 5 in each group developed minor respiratory illness	Commission on Acute Respiratory Diseases[3, 5]
Filtered nose, throat washings from cases of minor respiratory illness and primary atypical pneumonia	Subjects recovering from minor respiratory illness were susceptible to primary atypical pneumonia†	Commission on Acute Respiratory Diseases (personal communication)

*Individual isolation of inoculated subjects was not done. Results are inconclusive because of the possibility of cross infection.
†Results suggest that a number of filtrable agents, unrelated antigenically, are the cause of these illnesses.

and minor respiratory illness were produced in 10 of 12 subjects with unfiltered pooled throat washings and sputa from patients early in the course of the disease. The test subjects were kept in group isolation for six weeks, and the results were inconclusive because of the possibility of cross infection. In a second series of experiments[3, 5] the volunteers were placed in isolation in individual rooms to overcome this objection. Three of 12 persons receiving filtered specimens and 3 of 12 receiving unfiltered material developed atypical pneumonia. Five subjects in each group developed minor respiratory illness. These studies adequately demonstrate that bacteria-free filtrates, presumably containing a virus, can induce primary atypical pneumonia in man. In still another study, the Commission on Acute Respiratory disease showed that subjects recovering from minor respiratory illness were susceptible to primary atypical pneumonia, suggesting that a number of filtrable agents, unrelated antigenically, are the cause of these illnesses. These studies clearly show that primary atypical pneumonia "is at least initiated, if not caused, by a filter-passing agent, presumably a virus."

SUMMARY

Despite the vast amount of literature which is accumulating, little is actually known concerning the etiology of the majority of cases of atypical pneumonia. There is evidence from this review that a group of viruses, some related to the members of the lymphogranuloma-psittacosis group of viral agents, are capable of causing respiratory infections and pneumonia in man. Few, if any, of the several viruses that have recently been described have as yet proved to be of etiologic significance in more than an occasional case or small group of cases. The virus of ornithosis, for example, has been recovered from only a few patients with pneumonia, and the development of antibodies against this agent has been demonstrated in only a few others. In many of these cases, there was a history of exposure to infected birds. Evidence has been presented that pigeons and barnyard fowl carry viruses which may play an etiologic role in human infection. The frequency of human infections with these viruses, however, has not yet been fully demonstrated.

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ABSTRACT OF DISCUSSIONS

Dr. Ludwik Anigstein, Galveston: The comprehensive review presented by Dr. Sulkin gives evidence of the complex nature of the etiology of primary atypical pneumonia. While a small proportion of cases presenting this clinical syndrome are due to bacteria, fungi, and known viruses, the etiology of the majority of them remains to be investigated and identified. The experience gained so far, particularly the results of human experimentation by the Commission on Acute Respiratory Diseases, indicates that the disease can be caused by bacteria-free fil-

trates of the infectious material. In other words, the specific agent of certain cases of primary atypical pneumonia is filtrable and, with all probability, a virus. It is true that filtrability is the chief characteristic of such classic viruses as those of measles and influenza.

However, filtrability is also shared by a clearly visible and well defined organism which proved the causative agent of certain cases of pneumonitis. This organism belongs to the large and ever growing group which are the agents of such dreaded diseases as Rocky Mountain spotted fever, typhus, and tsutsugamushi, to mention only a few. These diseases are caused by the peculiar intracellular microparasites called rickettsiae.

Although the pathogenic rickettsiae in many respects behave like viruses, they are not filtrable under ordinary circumstances, with one exception, namely, the so-called Q fever rickettsia. The designation of the disease as Q fever originates from Queensland, Australia, where in 1935 a number of cases of a mysterious fever were observed. The onset was acute, accompanied by headache, pains and disorders of the respiratory tract. The patients exhibited a continuous fever of seven to twenty-four days duration and a slow pulse rate.

The causative agent of this disease was established by Derrick in 1938 as a rickettsia and the name R. burneti was given. Independently and almost simultaneously a very similar disease was described in this country by Davis in Montana, and the tick Dermacentor andersoni incriminated as the vector, whereas the Australian Q fever is transmitted by the tick Haemaphysalis humerosa. Two years later the National Institute of Health in Washington became the scene of a mass outbreak of an acute febrile disease among its personnel. A total of 15 persons was affected. Some of them suffered from respiratory disorders and pains in the chest, but all patients showed pneumonic shadows on roentgenogram. Although the roentgen examination gave the most typical evidence of soft, patchy, infiltrative lesions of the lungs, the physical examination showed only negligible findings. This absence of physical findings in the lungs which can only be demonstrated by roentgen examination is to be considered one of the characteristics of this type of pneumonitis.

The etiology of the disease was established by the demonstration of typical intracellular rickettsiae in guinea pigs and mice inoculated with the blood of the patients. Cross-immunity performed on animals recovered from the infection and challenged with established strains of American and Australian Q fever have definitely proved the rickettsial nature of this outbreak of pneumonitis. Filtration experiments with spleen suspensions containing the rickettsiae were performed in using Berkefeld "N" filters. These filters, which are capable of holding back ordinary bacteria and the rickettsiae of Rocky Mountain spotted fever, were permeable to the rickettsiae of Q fever. In other words, the filtrability of the agent of pneumonia was demonstrated.

The presence of Q fever rickettsiae in Texas (Liberty County) has been established by Parker and Steinhaus (1943), and the tick Amblyomma americanum found as natural vector.

Dr. Alfred W. Harris, Dallas: Dr. Sulkin's clarifying review of the present status of primary atypical pneumonia is extremely timely, for we have this illness among us in ever increasing numbers. Since physicians undoubtedly miss many other specific illnesses by placing them under this heading, all efforts to separate this particular disease, its cause, and the experimental production would seem to lead to keener diagnosis and possibly, in the future, to some therapeutic help. For this reason, I wish to emphasize that portion of Dr. Sulkin's paper dealing with the experimental reproduction of the illness. The Commission for Acute Respiratory Disease set up three elaborate experiments during the course of 1944 and made their reports available during 1945.

Briefly, finding that all attempts at experimental production of primary atypical pneumonia in a wide variety of animals were unsuccessful, they turned to the natural host, man. They had utilized chick embryos, chickens, doves, Java rice birds, mice, guinea pigs, ferrets, rabbits, dogs, three species of monkeys, cotton rats, kittens, and the mongoose in extensive trials without success. They attempted to determine whether or not the diseases were transmissible with secretions of the respiratory tract of ill patients and whether or not bacteria-free filtrates of such secretions were capable of inducing infection.

Their subjects were volunteers from a conscientious objectors' camp. Their first experimental group (August, 1943), consisted of 12 men free of any illness after an adequate survey of five days. These men were inoculated from a pool of untreated sputa and throat washings from 7 cases of atypical pneumonia. The sputa and washings were sprayed from an atomizer and nebulizer into the nose and pharynx of each volunteer. Respiratory illness of various degrees of severity developed in 10 of the 12 volunteers. As Dr. Sulkin pointed out, individual isolation of the test subjects was not used, and, therefore, the results may have been inconclusive because of the danger of cross infection. With such encouraging results, however, experiment 2 was carried out in June and July, 1944, utilizing 36 volunteers placed in isolation in individual rooms of a hotel. Quarantine was instituted for three weeks; then the subjects were divided into three equal groups. One group received untreated throat washings and sputa; the second group, the same material filtered through sintered glass and Seitz filters; and the third group, the same material autoclaved.

Among the 36, 10 cases of characteristic primary atypical pneumonia developed and 15 cases of minor respiratory illness of undifferentiated type. The clinical onset of the primary atypical pneumonia varied from eight to fourteen days after inoculation. Since some cases were produced without regard to the type of inoculum, a third set of experiments was carried out in August, 1944, to prove whether these results were specific or due to contamination by air borne infections or contamination of the air pump or possibly due to the evocation of a latent agent. The experiment was much the same except that pooled sputa and washings were from cases of primary atypical pneumonia produced in experiment 2 and the inoculations were done out of doors.

Again, 6 cases of atypical pneumonia and 11 cases of minor respiratory illness were produced. By making the control group larger, only one instance of minor respiratory illness developed from the autoclaved material and this in the only subject who was known to have broken isolation.

These results demonstrate that primary atypical pneumonia may be produced in human beings with filtered, as well as untreated, secretions of the respiratory tract of patients ill with the disease; that autoclaved material is without effect; and further, that a latent agent was not evoked.

Cold agglutinin tests were carried out. In the experimentally produced atypical pneumonias there was a significant rise in the cold agglutinin titer.

From these experiments it would seem that primary atypical pneumonia is caused by a filtrable agent, probably a virus.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic, or social condition.—Constitution, World Health Organization.

CONGENITAL ATRESIA OF THE ESOPHAGUS WITH TRACHEO-ESOPHAGEAL FISTULA

Report of Additional Cases

WILLIAM H. BRADFORD, M. D.
DALLAS, TEXAS

Definite progress in the surgical correction of congenital atresia of the esophagus with tracheo-esophageal fistula may be said to date from the realization by Mixter[8] and others in 1929 that gastrostomy as a complete method of treatment was a failure.

From that time on cervical esophagostomy, extrapleural ligation of the fistula, and dorsal esophagostomy were tried with variations of technique by Mixter,[8] Leven,[7] Carter,[2] and Gage and Ochsner.[3] By 1936, however, the difficulties of this many staged approach to the original problem combined with the esophagoplasty necessary ultimately led to its abandonment.

The approach next attempted was that of primary anastomosis of the two esophageal segments. This was first done[4] by Shaw[11] in 1938 using an extrapleural approach to the mediastinum. Haight[4] also reported cases repaired in this manner; later Ladd,[5] Poth,[9] and Lam[6] employed this routine. In 1944 Singleton and Knight[12] again advocated a transpleural approach suggested earlier by Richter.[10]

Two cases of this anomaly are here reported, in addition to 4 previously described.[1] Two patients in the 4 cases previously reported were operated on by Shaw[11] in the manner indicated above.

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Read before the Section on Pediatrics, State Medical Association of Texas, Annual Session, Galveston, May 7, 1946.

CASE REPORTS

CASE 5.—On August 24, 1939, a full term male infant was admitted to the nursery at St. Paul's Hospital on the service of Dr. W. E. Martin. Initial respiratory efforts were difficult, seemingly impaired by aspirated material from the birth canal. This difficulty returned periodically during the first few hours; stimulants and repeated suction of mucus from mouth and throat were necessary for resuscitation. An attempt to pass a gavage tube was unsuccessful and roentgen studies were begun. Portable roentgenograms of the chest anteroposteriorly revealed well aerated lung fields. The heart and diaphragm appeared normal. The supracardiac shadow measured 3.5 cm. Further investigation horizontally in anteroposterior and left lateral positions, after injection of iodized oil into the esophagus, revealed that the upper esophagus formed a dilated pouch which ended abruptly at the level of the second dorsal vertebra. Some of the oil entered the respiratory tract and a trace of the material was observed in the stomach (fig. 1).

A high Trendelenburg position was employed with parenteral fluids, omission of oral feedings, and aspiration of mouth and pharynx as needed. Unsuccessful attempts were made to give isotonic glucose solution rectally.

FIG. 1. (Left) Case 5. Iodized oil in the upper esophageal segment, some having found its way into the main bronchi. (Right) Case 5. Some of the iodized oil in the stomach.

On the third day the temperature rose to 102 F. and signs of bronchopneumonia were detected bilaterally. Sulfapyridine therapy was begun by rectum and some clinical response was obtained. A blood transfusion was given on the fifth day. On this day also, bronchoscopy and esophagoscopy were done by Dr. Robert Shaw and revealed that the upper esophagus ended as a blind pouch, while the lower esophagus opened into the trachea at the carina.

On the next day the following operation was performed: A vertical incision was made in the left back. Bits of the second, third, fourth, and fifth ribs were removed at the angle. The intervening muscle bundles were cut. The posterior mediastinum was entered in the extrapleural plane. A cord of tissue along the posterior surface of the trachea was seen to join the two esophageal segments. The lower end of the esophagus was located with difficulty, tied off at the trachea, and cut. The upper end of the esophagus was identified and opened. A T tube was placed in the opened ends with much difficulty and loosely sutured in place. The wound was loosely closed.

The patient did poorly throughout the procedure and had to be resuscitated frequently. There was too much blood loss and on the whole the operation went poorly. The patient died one-half hour following the conclusion of the operation. Permission for an autopsy was denied.

CASE 6.—W. S. W., a 3 day old boy, born at Good Samaritan Hospital, July 19, 1941, on the service of Dr. J. O. S. Holt, was admitted to Bradford Memorial Hospital on July 21 with the complaint of inability to swallow since birth and excessive drooling. An attempt to pass a gavage tube failed because of an obstruction slightly below the clavicle. Iodized oil was injected into the esophagus under fluoroscopy (fig. 2, upper left) and that organ was seen to end in a blind pouch at the level of the second thoracic vertebra. This was later confirmed by esophagoscopy, and bronchoscopy revealed the existence of a tracheo-esophageal fistula having its opening at the carina. The patient was placed in steep Trendelenburg position, mouth aspirations were done as needed, parenteral fluids were given, and vitamin K also was given. On the following day Dr. Shaw operated in the same manner as in case 5, except that an indwelling nasal catheter was used instead of a T tube, since the upper esophageal segment was short and did not permit an anastomosis without considerable tension. This accounted for much of the trouble in the postoperative period. On the third day after the operation an otitis media developed and the catheter was removed. Thereafter feedings were given by gavage. On the fifth postoperative day, however, the gavage tube came out through the wound incision in the back and a gastrostomy was performed by Dr. Shaw and feedings were given by this route for a time. The otitis having subsided one week later, on the twelfth postoperative day, an esophagoscopy was done and with difficulty a wire was passed into the stomach. To this a double strand of silk suture was tied and brought back through the mouth. Using this complete circuit either a catheter was used or a metal dilator (fig. 2, upper right) to introduce or to precede feedings (fig. 3). An episode on the forty-third day—aspiration of regurgitated formula—caused severe cyanosis and bronchoscopy was necessary. On the fiftieth day a wound infection developed in the region of the right scapula and was

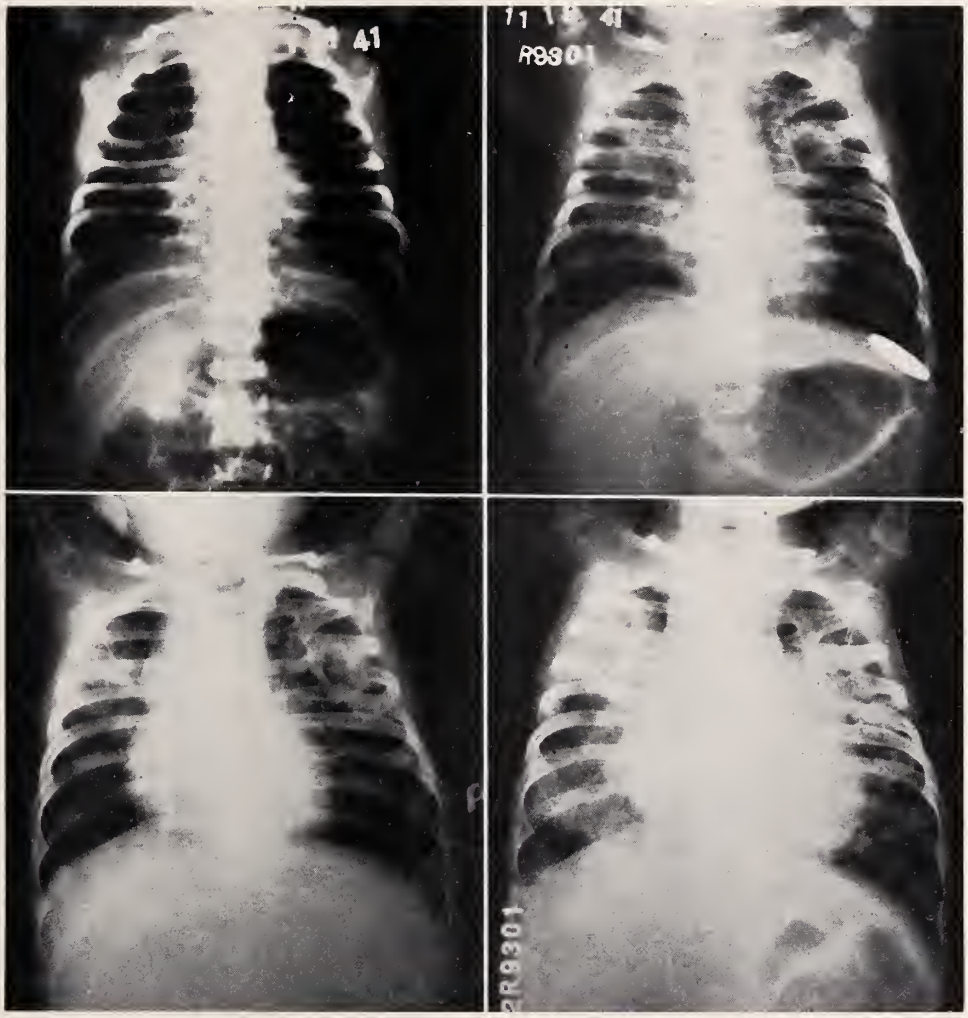

FIG. 2. (Upper left) Case 6. Iodized oil used to visualize the upper esophageal segment and air in the stomach and intestines proving the presence of a tracheo-esophageal fistula.
(Lower left) Case 6. Right upper lobe pneumonia. Note further rib regeneration.
(Upper right) Case 6. Use of a metal dilator on silk thread. Note regeneration of ribs at operative site.
(Lower right) Case 6. Generalized bronchopneumonia (terminal).

slowly relieved by open drainage. Episodes of respiratory infection ensued, alternating with difficulty involving the esophageal stricture. Weight gain, however, was steady despite the febrile periods. Almost four months after operation another occasion of aspiration of feeding seemed to be the cause of development of a right upper lobe pneumonia (fig. 2, lower left). Sulfathiazole therapy was employed with a prompt response. This process was duplicated completely almost three weeks later.

At slightly more than five months of age, cereal feedings were begun and the Horner's syndrome on the left, present since operation, was still observed although much less evident than when first noted.

From this time on repeated episodes of respiratory infections, an aspirational type of bronchopneumonia, were frequently encountered. These were usually controlled by sulfathiazole, sulfadiazine, and blood transfusions. It really seemed the baby learned better how to vomit than to swallow. The wound in the chest healed as did the gastrostomy wound. There were brief febrile periods but weight gain continued steadily, reaching 17 and a fraction pounds shortly before death. On the three hundred sixty-sixth day of life another respiratory episode similar to the preceding ones occurred but did not respond as before (fig. 2, lower right). Death ensued on the three hundred seventy-fifth day. Permission for autopsy was denied.

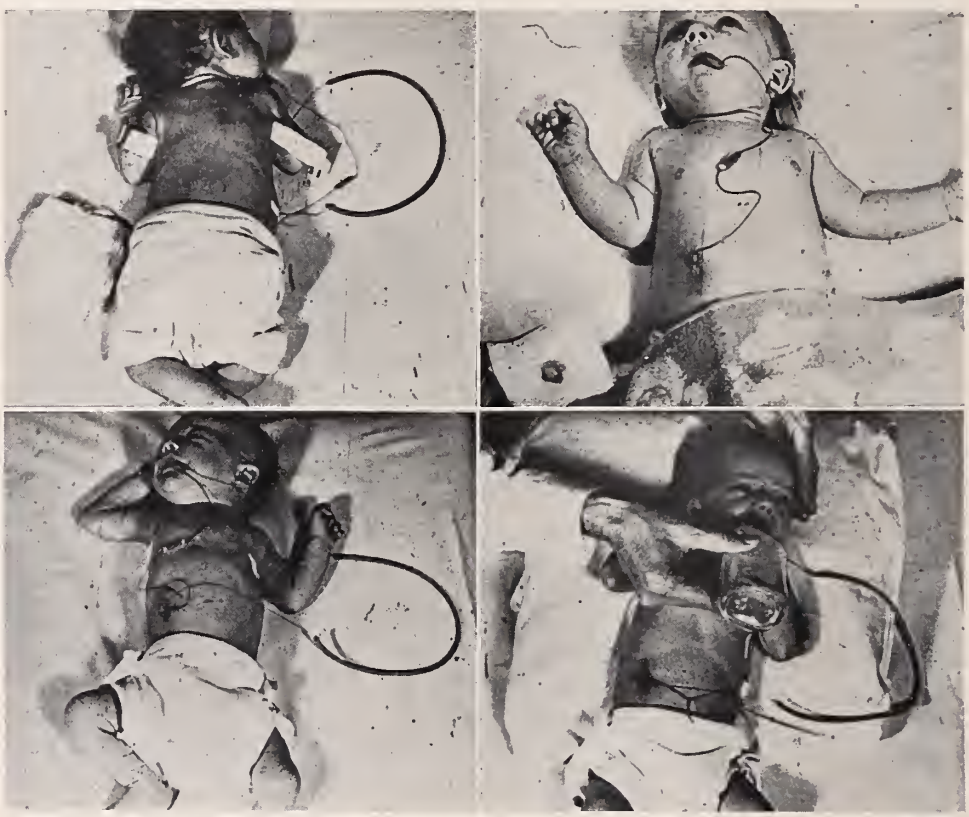

FIG. 3. Case 6. Photographs showing the operative site (upper left), the use of a metal dilator (upper right) and catheter (lower left) for esophageal dilation, and the method of feeding (lower right).

COMMENT

The diagnosis of this anomaly is primarily a pediatric problem and difficulty in its recognition lies largely in a failure to consider its possible existence whenever vomiting, coughing, strangling, or respiratory difficulty occurs within the first few hours of life.

The symptoms produced are quite constant. The infant externally presents no unusual appearance except that of drooling. Periods of choking and cyanosis—even apnea, with gradual recovery—occur between feedings. Any feeding or water is taken avidly but after a few swallows the symptoms above are repeated. After observing this, if any doubt remains, an attempt at passing a gavage tube is indicated and if an obstruction is encountered, more extensive investigation will naturally follow. If the condition is not recognized early, however, or has gone on to the development of an aspiration pneumonia by the time it is seen, considerable difficulty in determining the underlying cause may ensue. It is possible, then, that this anomaly has a higher incidence than is reported.

Roentgen investigation may consist of the customary flat plate taken at the beginning. If air is present within the stomach and intestines, the presence of a tracheo-esophageal fistula may thereby be confirmed, assuming that further investigation reveals a com-

plete atresia of the upper esophagus. The absence of air in these parts, however, does not preclude the existence of the fistula. Haight[4] has encountered several cases in which agenesis of the distal segment was to such degree that only a very narrow lumen was found. The injection of a small amount of iodized oil—never barium—into the upper segment usually reveals a patulous, completely atretic portion terminating as a rule at the level of the second thoracic vertebra.

Upon establishing the presence of even the latter of these two conditions surgical consultation is in order. In this field lie valuable preoperative diagnostic procedures, that is, bronchoscopy and esophagoscopy. The former may be of invaluable assistance in locating the opening of the fistula, whether at the carina, above it, or to the right or left of the tracheal bifurcation. A mark can then be made upon the instrument at the alveolar process and a similar one upon investigating the distal end of the upper esophagus. By comparing these two an accurate estimation of the distance between the segments can be obtained.

Preoperative and postoperative treatment are of great importance. As soon as the condition is suspected the infant should be placed in a steep Trendelenburg position with aspiration of the mouth and throat as often as necessary. Nourishment should be provided parenterally, namely, 3 to 5 per cent glucose solution in distilled water avoiding the danger of sodium retention mentioned by Haight.[4] Whole blood transfusions are to be preferred to the giving of plasma. Postoperatively, also, these injections are continued to supplement the small amounts of formula given in the first few days.

The type of the anomaly described in the case reports is found in about 80 to 90 per cent of the total cases. Figure 4 shows also those less frequently encountered. The fundamentals of diagnosis apply as well here.

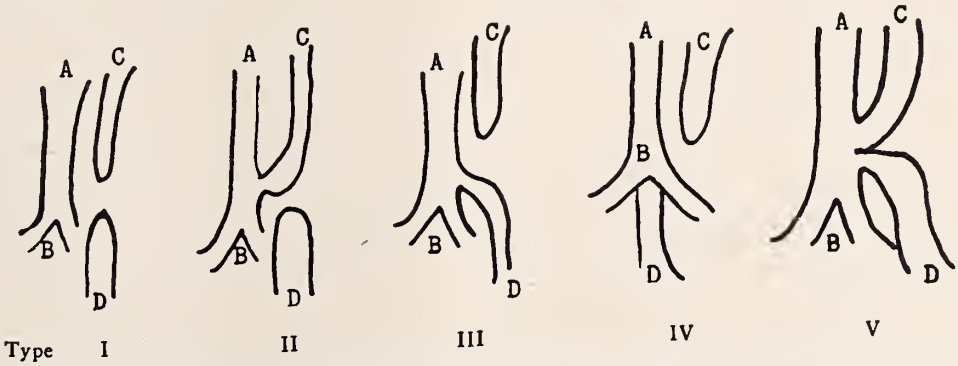

FIG. 4. Diagram showing the arrangement of the trachea and esophagus in the arious types of esophageal atresia and tracheo-esophageal fistula. The letters refer to the following structures: *A*, trachea; *B*, bifurcation of trachea; *C*, upper segment of esophagus; and *D*, lower segment of esophagus. [After Ladd: New England J. Med. 230:625 (May 25) 1944.]

CONCLUSIONS

The history of progress in the surgical correction of congenital esophageal atresia with tracheo-esophageal fistula may be said to date from the abandonment of gastrostomy as a curative measure. Two additional cases are reported, with repair by direct anastomosis using an extrapleural approach, the second patient having lived for more than one year following operation.

Emphasis is placed upon early diagnosis since this is primarily the obligation of the pediatrician.

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ABSTRACT OF DISCUSSION

Dr. Robert R. Shaw, Dallas: This paper by Dr. Bradford is a timely one. It has been only during the past seven years that any hope could be ascertained for the survival of patients with congenital atresia of the esophagus with tracheo-esophageal fistula. An early diagnosis is particularly important. The immediate threat to life in this condition is aspirational pneumonia caused by either aspiration of the mouth secretions which cannot be swallowed or of the gastric secretions which gain access to the tracheo-bronchial tree by way of the lower esophageal segment. As soon as this condition is suspected the baby should be placed in a prone position with

head lower than the rest of the body. Those in attendance should aspirate mucus and saliva from the mouth. It is important that surgery be carried out as soon as arrangements can be made. If there is any delay, clyses should be given to maintain a fluid balance. It has been established that a direct attack upon the fistula through an extrapleural approach is feasible. An anastamosis of the esophagus can be effected depending upon the length of the atresia. If the defect is too great only closure of the fistula should be attempted. There are approximately twenty babies living who have survived an operation of this type. The mortality is still high but with early diagnosis and improved technique, a much greater percentage of these babies can be restored to normal.

Dr. Bradford, closing: Rosenthal* has remarked that the incidence of these cases is higher after a medical meeting at which the condition is discussed. Early recognition and surgical care in the manner described will surely lead to a reduction in the mortality rate of infants having this anomaly.

*Rosenthal. A. H.: Congenital Atresia of the Esophagus with Tracheo-Esophageal Fistula (3 Cases), Am. J. Obst. & Gynec. 33: 646 (1937).

PHYSIOLOGICAL CHANGES DURING SPINAL ANESTHESIA

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It is often said, and correctly so, that spinal anesthesia provides the best muscle relaxation of all available types of anesthetics. Too often the operator selects spinal anesthesia for the convenience this relaxation affords and disregards the patient's ability to withstand it. When a local anesthetic drug is injected intrathecally more changes occur than the readily apparent loss of sensation and paralysis of muscles. In high spinal anesthesia denervation is complete in the sacral, lumbar, and most of the thoracic segments as far as the sensory and motor nerves are concerned. However, the autonomic fibers are variously affected. Both the sympathetic and parasympathetic components of the autonomic nervous system are inactivated in the lower spinal segments. In the thoracic segments, however, most of the sympathetic fibers are blocked, but the parasympathetic fibers, since they arise from the cranial nerves, particularly the vagus, remain active. This partial denervation of certain components of the autonomic nervous system in the upper part of the body and complete denervation in the lower part, coupled with the somatic nerve paralysis, initiate a number of physiological disturbances even in persons not subject to operation. The disturbances become even more complex when the effects of trauma, blood loss, and other results of surgery are superimposed. The compensatory mechanisms which operate to overcome these changes may not be as effective in the presence of disease. The disturbances, therefore, are complicated further by the diseases encountered in surgical patients. Familiarity with the disturbances encountered during spinal anesthesia is essential intelligently to select patients suitable for the technique and to deal with the systemic derangements which may be encountered. Many of the physiological changes observed during spinal anesthesia are of practical significance; others are merely of academic interest. It is the purpose of this paper to emphasize changes of practical significance in surgery.

Of all the changes encountered, those affecting the circulatory system are undoubtedly the most important. The hypotension which accompanies subarachnoid block is familiar to all who employ this form of anesthesia. Certain characteristics of the hypotension differentiate it from hypotension from other causes, particularly that observed in shock from trauma or hemorrhage. Usually the hypotension appears shortly after induction of anesthesia and usually not until motor paralysis is well established. The systolic pressure falls out of proportion to the diastolic. The diastolic pressure is usually well maintained, or falls slightly unless the physiologic disturbances are severe. The pulse pressure therefore is reduced. A bradycardia is almost invariably present, particularly if premedication is omitted and if the extent of anesthesia is "high." The mechanism causing the hypotension is not understood exactly, even though numerous experimental studies and clinical investigations upon the subject have been reported. It is agreed the circulation fails somewhere in the periphery rather than centrally.[3] The well maintained diastolic pressure, the lowered systolic pressure, the bradycardia, and the diminished pulse pressure are reasonable indications that little change occurs in peripheral resistance and that there is a decrease in stroke volume. Studies on cardiac output confirm this latter supposition.[2] The circulation time is prolonged. The arteriovenous difference is widened, since the arterial oxygen saturation remains unchanged in the face of a reduced venous oxygen content.

For some time sympathetic paralysis, with its concomitant arteriolar dilatation and subsequent pooling of blood in the peripheral and splanchnic vessels, has been ascribed as the mechanism causing the hypotension in spinal anesthesia. That arteriolar dilatation with subsequent pooling of blood occurs in the peripheral vessels is well borne out by the increase in skin temperature, absence of sweating in the anesthetized area, and in-

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crease in the volume of the limbs in pletismographic studies. However, recent clinical investigations indicate that the splanchnic vessels do not undergo dilatation even though there is loss of sympathetic activity. Instead, there appears to be an autonomous control of the tone of the arterioles within the vessels themselves. When denervation occurs and the vessels are no longer under central control, this autonomous control comes into play. Thus tone in the vessel wall is maintained and the caliber of the vessels is altered little. Generalized vasodilatation in the vessels of the viscera does not take place as was formerly supposed. Generalized dilatation of the entire arteriolar bed would reduce peripheral resistance, which would in turn be manifested by a lowering of diastolic pressure. The pooling of the blood in the peripheral vessels and in the spleen, which dilates two or three times its normal size under spinal anesthesia, has been estimated to contribute to approximately 10 per cent of the lowering in blood pressure. By far the greater portion of the lowering in pressure is now ascribed to the failure of the venous portion of the circulatory system. The return of venous blood to the heart depends upon the support and "milking action" of skeletal muscle and variations in the intra-abdominal and intrathoracic pressure.[4] The return of blood to the heart therefore is greatly retarded by the loss of muscle tone if skeletal muscle is denervated. The greater the extent of motor paralysis the more striking the circulatory depression which ensues. The greater the number of spinal segments anesthetized the greater the amount of muscle tissue denervated, and the greater the stagnation which is present in the vessels and capillaries. Furthermore, in the "high spinals," in which the paralysis is in the thoracic segments, intra-abdominal tension and intrathoracic pressure are reduced and contribute further to venous stagnation. Hypotension, therefore, depends largely upon the extent and intensity of anesthesia. Intensity of anesthesia depends upon dosage.[1]

When a nerve fiber composed of sensory, autonomic, and motor fibers is exposed to varying concentrations of a solution of local anesthetic drug, it is found that the sensory fibers are more sensitive to the weaker solutions; motor fibers are most resistant. Apparently this behavior is a function of fiber size rather than of chemical constitution. In any event, a given dose of an anesthetic drug may be so distributed in the spinal canal that it comes into contact with the anterior and posterior roots of many segments. The concentration of the drug is so reduced that only sensory anesthesia, with little or no motor paralysis, may be obtained. The greater the number of components of a mixed nerve which are blocked the greater the intensity of anesthesia. On the other hand, the dose may be so increased that both sensory and motor fibers are involved. When muscle relaxation is required for surgery of the upper abdomen, the dose must be such that a concentration of the drug sufficient to block the motor components of the nerves supplying the muscles is present in the thoracic region. Consequently, dosage plays a role in circulatory disturbances of spinal anesthesia. The larger doses cause more profound changes because they yield a greater intensity of anesthesia. Profound physiologic disturbances are often ascribed to the longer lasting drugs such as pontocaine or nupercaine because they are more toxic, when in reality it is the intensity of the anesthesia which is to blame. Over estimation of dosage is more likely with longer lasting drugs since relatively smaller quantities compared to the less potent drugs are required to establish a given intensity of anesthesia.

The hypotension is often termed "spinal shock" by clinicians. It differs in a number of respects from shock caused by trauma, hemorrhage, or reflex stimulation. Although systolic and diastolic and pulse pressure are all reduced, the hypotension is neurogenic in origin, and blood volume at the outset is not appreciably disturbed. Venous pressure is lowered in the arm veins. Hemoconcentration does not occur since blood specific gravity and red blood cell count are not significantly altered. The disparity between the vascular bed and blood volume is due to a relaxation of the vascular bed rather than a reduction in total blood volume. In traumatic shock or shock from hemorrhage the reverse holds true. Vasopressor drugs readily overcome the derangement in spinal anesthesia, presumably by decreasing the volume of the vascular bed. Fluids are relatively ineffective unless given rapidly in very large amounts. In shock from trauma or hemorrhage the reverse is true. "Shock" in spinal anesthesia usually manifests itself as soon as analgesia and motor paralysis are established, that is, within the first few minutes. Hypotension occurring after the operation has been in progress some time, as a rule is ascribable to the effects of surgery and is corrected by administration of fluid.

The mechanisms which cause circulatory adjustment, which are under control of the autonomic and central nervous systems, no longer operate, or do not operate effectively, in spinal anesthesia. Inhalation of carbon dioxide, which ordinarily causes an elevation

of blood pressure in the unanesthetized subject, no longer produces this effect because the fibers from the vasomotor center are blocked somewhere along their course. The skin in the unanesthetized area is pale, the vessels are constricted, and the temperature is reduced—all manifestations of attempts to overcome the derangements of the circulatory system. In the anesthetized area in "high spinal" anesthesia, the sympathetic nerves are paralyzed but the vagus remains active. The pulse rate, therefore, becomes reduced. Inability of the compensatory mechanisms to cause readjustment assumes practical significance when patients are shifted from one position to another. Marked degrees of circulatory depression frequently accompany the assumption of Trendelenburg, lateral, prone, and other positions. Likewise, experienced spinal anesthetists have for some time recognized that spinalized subjects do not tolerate even mild degrees of hemorrhage.

Obviously, an impaired circulatory system withstands the assault of an anesthetic procedure which causes such circulatory derangements to a lesser degree than one without any obvious defects. The most severe circulatory disturbances occur in patients who have cardiovascular diseases, anemia, shock, or dehydration. Patients who have increased intra-abdominal tension, whether from ascites, intestinal obstruction with marked gaseous distension, large tumor masses, or pregnancy, also develop severe hypotension after induction of spinal anesthesia. The exact mechanism is not understood but it is believed to be caused by impairment of flow in the large veins in the abdomen.

Circulatory disturbances in turn cause metabolic changes in the tissues. The widened arteriovenous difference suggests the possibility of local tissue anoxia. Spinal anesthesia without circulatory disturbances does not affect general body metabolism to any remarkable extent. Blood glucose, nonprotein nitrogen, and combining power values are not significantly altered. Liver function likewise is not significantly affected. However, hypotension, particularly if not promptly treated, causes impairment of hepatic function. Glomerular filtration and tubular excretion and reabsorption likewise are not significantly affected.

The effects of spinal anesthesia upon smooth muscle of the bowel and the uterus, are of practical significance. The portion of the gastro-intestinal tract innervated by the vagus assumes a ribbon-like, contracted appearance when anesthesia extends into the thoracic segments sufficiently high to cause sympathetic paralysis. The motor effects of the vagus becomes prominent. Furthermore, traction upon the mesenteries of the abdominal viscera often causes discomfort because of retrograde transmission of impulses along the vagus, or from one ganglion to the next along the sympathetic chain. The effects of spinal anesthesia upon the uterus are variable. Sensory fibers enter the uterus from the sacral and lower lumbar segments, motor fibers from the thoracic segments. If the drug is confined to the lower spinal segments, uterine contractions are not inhibited. If the autonomic fibers of the thoracic segments are affected, a diminution of intensity and frequency of contraction of the uterus is observed. In any event the uterus does not relax but maintains its tone as usual.

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A REVIEW OF 9,000 OBSTETRICAL CASES AT THE HARRIS MEMORIAL METHODIST HOSPITAL, FORT WORTH, TEXAS

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This is a complete report of the activities in the obstetrical department at the Harris Memorial Methodist Hospital, Fort Worth, covering a period of five years, 1941 to 1945 inclusive, and more than 9,000 cases. This compilation includes all patients delivered on and after the period of five months and term pregnancies. There has been no garnishing of this report. Every patient who entered the hospital has been faithfully reported on and the outcome recorded. No effort is made to present anything new in the conduct of the obstetrical case; no suggestion is being made as to the conduct of the obstetrical case; but a careful notation of facts concerning procedure, with the results obtained, pertinent to mother and child are recorded with the hope that the readers may profit to some extent from the experience of the collaborators in this report.

It should be remembered that during the period reported on there has been a war, and so far as obstetricians and gynecologists are

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concerned there is still a war. No one must forget the handicaps under which the veterans of World War I labored during World War II, namely, limited hospital accommodations, inadequate nursing facilities, and an over supply of babies which follows no economic law. May it be said that there has been no case of a member of the armed forces whose wife or immediate dependent needed obstetrical care, who was refused by this group of collaborators regardless of whether or not the service was covered by the Emergency Maternal and Infant Care Program, and this program was disregarded in many, many cases. Credit, too, must be given to the hospital and to the excellent group of nurse anesthetists who coöperated to make this report on a par with the statistics compiled during peace times prior to this period.

A brief word of explanation is in order as to the physical setup of this institution. The obstetrical section has a normal capacity of 40 patients, that is, a daily census of 40 patients, but even at the date of this report, no single room is without 2 patients for a long period of time and there is usually a minimum daily census of 65 mothers and babies. There has been no increase in nursing personnel. As a matter of fact, there has been a decrease since the termination of the Nurses Cadet Corps. As a result of this discontinuation, it has been necessary to employ nurses' aids. These persons undergo a very short period of training which enables them to do perineal care, give patients baths, and answer the lights, but of necessity requires them to report to the nurse in charge of this section any medication necessary for the patient's comfort or relief. Apparently this is going to be the future of hospitals, namely, a highly educated nursing supervisor plus the necessary nurses' aids, which, unquestionably, is one of the revolutionary factors in nursing and certainly does not seem to conform to the ideals so wonderfully exemplified by Florence Nightingale. But such is the march of Time.

There has been, too, a shortage of interns and residents in this department so it has been necessary for the attending physicians to receive the patients on admission, order the most routine procedure for perineal care, prenatal medication, supervise its administration, note the progress of labor, coöperate in the delivery of the patients, and supervise the postpartum care. At this institution these procedures have been willingly cooperated in by all the attending physicians. It has been possible to conduct a broad obstetrical program on a level which is fairly comparable to that of the prewar period.

Prenatal observation of the patients listed in the accompanying charts was made either by collaborators in this program or by resident staff members of the hospital on the out-patient clinic. Approximately 8 per cent of the total number listed were cared for by general practitioners or were emergency patients from communities outside of Fort Worth.

On admission, all patients, if time allowed, were given preparation and enema. Preparation consisted of being shaved, cleansed with soap and water followed by a cyanide solution, having blood pressure checked and recorded, fetal heart sounds determined, and the progress of labor noted by nurses and interns. Usually one of the attending physicians was actually on the floor and coöperated in observing all the patients in labor and accepted calls for advice from the nursing personnel as to the postpartum recovery.

ANALGESIA

One hundred per cent of the patients admitted were given analgesia in some form. The principal types used were barbiturates, barbiturates with scopolamine, demerol with scopolamine, and caudal analgesia. Ninety per cent received the combination of barbiturates or barbiturates with scopolamine. Nine per cent received demerol with scopolamine, and approximately 1 per cent received no adequate amount of analgesia, analgesic drugs, or were given caudal analgesia. A brief discussion of each procedure follows:

Barbiturates or Barbiturates with Scopolamine.—As soon as it was determined the patient was actually in labor and having regular contractions with some dilatation, she was given barbiturates, usually a combination of seconal grains 3 with nembutal grains 3 orally. This was followed within two to three hours, if progress was not too rapid, by 3 grains of seconal and nembutal orally. If progress was rapid she was given from 2 to 3.75 grains nembutal intravenously. Scopolamine in doses of .005 to .01 grains were given subcutaneously if amnesia was not secured. Upon complete dilatation, the patient was then transferred to the delivery room where a terminal anesthetic of ethylene and oxygen was used.

Demerol and Scopolamine with Barbiturates.—As soon as the patient was admitted to the hospital, prepared, an enema given, and determination made that she was in labor, contractions every two to four minutes with from 2 to 4 cm. dilatation, she was given 3 grains preferably of seconal orally. From thirty to forty minutes afterward if the labor was not markedly retarded by this oral medication and if the patient was a primipara and was expected to be in labor for several hours, she was given 100 mg. of

demerol plus .01 grain of scopolamine intramuscularly. Demerol 50 mg. subcutaneously may be repeated every two to four hours with scopolamine .005 grain repeated every one to two hours until total amnesia is observed. If a patient is admitted, progressing rapidly, and expected to be delivered within two hours, 50 mg. demerol may be given intravenously, taking one full minute for administration, plus .01 grain scopolamine intramuscularly and 50 mg. of demerol every two to four hours and .005 grain scopolamine every forty to sixty minutes until amnesia and analgesia are secured. Approximately 12 per cent of all patients given demerol intravenously show some nausea and vomiting which, however, is transient and is frequently of value when patients enter the hospital with full stomachs. A terminal anesthetic of ethylene and oxygen was always used.

Caudal Analgesia.—Because of the extraordinary amount of work in obstetrics and a shortage of personnel, together with lack of trained personnel to attend caudal cases, only a small per cent of patients were given caudal analgesia and anesthesia. However, those patients on whom this procedure was used were highly pleased. The method was universally successful. It was observed, however, that this procedure demanded a great deal more time of the person who administered the caudal preparation as well as demanding a trained person. The method used was that so successfully developed and used by Drs. Robert A. Hingson and W. B. Edwards.

Anesthesia.—The type of anesthesia used is described by Lundy as being a combined anesthesia of the obstetrical variety. Large amounts of preoperative drugs were used, and therefore a small amount of inhalation anesthetic was necessary, which certainly is advisable so far as the fetus is concerned, inasmuch as large percentages of oxygen may be used and a satisfactory anesthesia is obtained. For this purpose the collaborators of this program used ethylene and oxygen, but occasionally it was necessary to add ether to obtain sufficient relaxation for some obstetrical operative procedures. Chloroform was not used; open ether was rarely, if ever, employed. The obvious value of using ethylene and oxygen is that frequently as high as 50 per cent ethylene and oxygen is sufficient to obtain the level of anesthesia required for the usual operative obstetrical process. No explosions have been recorded at this institution and there was a minimum of respiratory irritation caused by use of ethylene and oxygen.

A summary of the procedures with results follows:

In the report of cases in table 1 it is noted that cesarean sections were done in 4 per cent of the cases, which is low.

The percentage of use of elective forceps, which includes any application of forceps,

TABLE 1.—*Procedures and Results in 9,307 Obstetrical Cases.*

	1941	1942	1943	1944	1945	Total	%
Total deliveries	1,072	1,536	1,987	2,253	2,459	9,307	
Spontaneous	322	404	523	435	407	2,091	22.5
Cesarean	47	65	73	108	86	379	4
Forceps elective	703	1,072	1,508	1,696	1,910	6,889	74
Breech presentation	37	65	77	106	93	378	4
Stillborn	9	22	30	32	37	130	1.4
Multiple pregnancy	7	14	20	25	12	78	.8
Tube section	51	65	134	123	120	493	5.3
Laceration 1st or 2nd degree	88	146	185	144	46	609	6.5
Episiotomy	798	1,139	1,535	1,785	1,789	7,046	75.7
Version and extraction					9	9	.09
Eclampsia		2	3	3		8	.08

below the level of the ischial tuberosities, seems high, but this procedure is routine with the chiefs of the obstetrical section at Harris Hospital and covers rotation with control of the rapidity of the presenting part as well as application of forceps to the after coming head in breech extractions.

Stillbirths occurred in 1.4 per cent of the cases. The analysis is reflected in tables 2 and 4.

Section of the fallopian tubes to produce sterility was done after the method of Madlener and Pomeroy immediately following delivery, using the same anesthetic employed during delivery of the patient. This is a matter of convenience and as yet has proved no hazard to the mother.

Episiotomies were done in 75.7 per cent of cases. The most frequently used method was the central or median type and in the hands of the experienced operator it has appeared to cause no greater difficulty for the patient, causes less pain, and gives results satisfactory to the operator. Version and extraction were used in only a small percentage of cases and employed only when exigency demands.

Eclampsia is not very prevalent in this part of the country. Only 8 cases of eclampsia occurred in this five years study and no patient has died as a result of this disorder. This low incidence of eclampsia may have been the result of careful prenatal care observed by the attending physicians of this hospital and also the receptive attitude of the public of this area toward close attendance upon out-patient clinics and the attending personnel.

The incidence of puerperal sepsis should be noted. Only 1 patient at full term has died as a result of puerperal sepsis. No explanation is made relative to this low incidence,

but it may be said that prophylaxis is the important factor and with the advent of penicillin and sulfonamides there has been a lowered mortality rate.

At this juncture it might be well to mention abortions. During the period of five years there have been 556 abortions with a maternal mortality of 5. With 9,307 deliveries, there has been a maternal mortality of 9. Thus it would seem that the ratio of maternal mortality in abortions is 10 per 1,000, with maternal mortality rate in term or near term deliveries 1 per 1,000. Only 1 of the patients died as a result of puerperal septicemia. A brief resume of the maternal deaths at or near term follows:

CASE REPORTS

CASE 1.—Mrs. J. W. T., at term, entered the hospital in labor and within a few hours was delivered spontaneously of a normal male child. She had no dilatation upon admission. She was given small doses of quinine, minims 1, pituitrin hypodermically to stimulate contractions. A tube section after the technique of Madlener was performed immediately following the delivery. Her temperature upon admission was 101 F. She was seen in consultation by one of the attending physicians. From then on, the temperature assumed a septic character and the patient died nine days postpartum. An autopsy was performed. The pathologic diagnosis was acute septic colitis, multiple perforation of the ascending and transverse colon, and suppurative peritonitis.

CASE 2.—Mrs. D. C. D., age 22, was admitted to the hospital December 24, 1943, and delivered that day at 1:10 p. m. Elective low forceps with median episiotomy were used. She recovered satisfactorily and was discharged December 30. She continued to bleed moderately and was readmitted on January 10, 1944, on gynecological service. A curettage was done and a piece of placenta was removed. The physician who attended her at delivery was out of the city and she was attended subsequently by another of the attending physicians who knew nothing of her previous delivery. She was transfused immediately after curettage with 500 cc. of citrated blood and immediately afterwards another infusion of blood was begun. The patient developed a severe chill and died within a few hours, having had a severe transfusion reaction. It was found on careful typing that she had a negative Rh factor and she was given Rh positive blood.

CASE 3.—Mrs. M. R. A., age 21, was admitted to the hospital July 24, 1944, and died July 28. This patient was admitted at 3:45 a. m. with a temperature of 100 F., pulse 120, respiration 30. She admitted having had a fairly large noon meal and having eaten ice cream prior to her admission to the hospital. Her medication was 3 grains of seconal, 3 grains of nembutal by mouth, and forty minutes later was given 3.75 grains by vein. Her labor was rapid, precipitous almost, and during its course she vomited frequently. With ethylene and oxygen as terminal anesthetic she was delivered spontaneously with a median episiotomy. Immediately afterwards she became cyanotic and aspiration was attempted with the addition of an oxygen tent for cyanosis. Immediately a diagnosis of aspiration pneumonia was made, unanimously concurred in by the consultants. Death occurred five days postpartum. An autopsy was performed. The final diagnosis was peribronchial abscesses multiple, lobular pneumonia, and foreign bodies in bronchioles.

CASE 4.—Mrs. G. L. C., entered the hospital November 5, 1943, with a diagnosis of pregnancy near term, placenta previa. She died November 25. No autopsy was performed. The operation was cesarean section and subsequent drainage of pelvic abscess. The clinical diagnosis was pelvic abscess with generalized peritonitis.

CASE 5.—Mrs. M. K. W., was admitted with a diagnosis of pregnancy at term. She was delivered with elective low forceps; median episiotomy was performed, and she was immediately given plasma. She died September 27, 1943. The diagnosis was acute myocarditis. No autopsy was performed.

CASE 6.—Mrs. F. B., was admitted with diagnosis of pregnancy at term, gravida 3. She was admitted December 19, 1942, at 4:30 a. m. and was delivered at 2:20 p. m. Elective low forceps and median episiotomy were used. She suffered an uncontrollable postpartum hemorrhage and died at 5:05 p. m. No autopsy report was secured.

CASE 7.—Mrs. K. E. J., was admitted to the hospital December 10, 1944, at 6:30 p. m. She was delivered the next day by cesarean section, presumably classical. The operation consumed a period of one hour. Nitrous oxide and cyclopropane with oxygen were used as an anesthetic. Two days later the patient developed fever, had a severe chill, and died on the third postoperative day. The pathologic diagnoses were lobar pneumonia, bilateral, and red hepatization, with a patent foramen ovale.

TABLE 2.—*Fetal Deaths.*

Number Hours Lived	Months of Gestation						
	5	5.5	6	7	8	9	Total
1			6	1	3	7	17
2		1	4	1	1	2	9
3			6	2			8
4	1		4	1	1	1	8
5			2			2	4
6-11	1		8	11	4	7	31
12			8	10	1	4	23
24			5	2	2	6	15
36	1		4	3	1	4	13
48				4		3	7
72			4	4		6	14
9 days				1		4	5
13 days						2	2
1 mo.			2	1	1		4
2 mo.			1		1		2
3 mo.				1			1
Total	3	1	53	43	14	49	163
Total deliveries in 5 years							9,307
Total stillborns from 5.5 to 8 months gestation in 5 years							114
Total full term newborn deaths							49

CASE 8.—Mrs. J. R. D. was admitted to the hospital in labor June 18, 1945, at 10:50 p. m. She was delivered at 5:15 a. m. the following morning by elective low forceps with median episiotomy. Immediately upon being placed on the table the patient was started on an inhalation anesthetic. She began vomiting a large amount of undigested food and died within a few minutes after the anesthetic was begun. The anesthetic was ethylene and oxygen. No autopsy was done.

CASE 9.—Mrs. J. C. C. was admitted to the hospital on April 10, 1945. The diagnosis was pregnancy at term, gravida 1. She was delivered the same day at 7:05 a. m. by elective low forceps with median episiotomy. On the sixth day postpartum the patient developed gastro-intestinal symptoms, nausea and vomiting, with increased temperature and died April 30. Autopsy showed acute intestinal obstruction with gangrene of the terminal ileum.

Fetal deaths are catalogued in table 2, the month of gestation being taken from five months to term. This arbitrary period

is in accord with the state law which requires submission of birth certificates and death certificates for all fetuses delivered from five months to term. For convenience it has been the policy, as recommended by many authorities, to classify all births before five months gestation as abortions, which have been mentioned previously. It seems advisable to classify births from seven months to term as viable and deaths of those infants are reflected in table 3. The total number of deaths from five months to term period of gestation for 9,307 deliveries has been 163, while there have been only 114 deaths up to near term, and 49 full term newborn deaths of infants who lived from one hour to two months.

TABLE 3.—*Deaths Occurring After Birth.*

Cause of Death	Months of Gestation 7	8	9	Total
Unknown			6	6
Prematurity	37	15		52
Congenital atelectasis	6	4	12	23
Spina bifida	2			2
Patent ductus arteriosus	3		2	5
Macerated fetus	2			2
Malnutrition		1		1
Erythroblastosis		3	4	7
Congenital deformity of heart		4	1	5
Tear of tentorium cerebelli		3	6	9
Monstrosity			3	3
Pneumonia		1	1	2
Tetany of newborn			1	1
Intraventricular septal defect			2	2
Acute entero-colitis		1		1
Total	51	32	38	121

Incidence: 12 per 1,000.

The causes of deaths are to be observed in table 3. The deaths occurring from seven months period of gestation to term total 121 or approximately 12 per 1,000. The most frequent cause was, first, prematurity; second, congenital atelectasis; and third, erythroblastosis. The diagnosis of all of these deaths were made clinically and by autopsy examination.

TABLE 4.—*Stillbirths.*

Cause of Death	Months of Gestation 7	8	9	Total
Cause unknown		1	6	7
Prematurity	8	3		11
Spina bifida	1			1
Macerated fetus	4	7	2	13
Monstrosity		2		2
Asphyxia in utero			1	1
Prolapsed cord			1	1
Total	13	13	10	36

Incidence: 3 per 1,000

The stillbirths in table 4, were caused predominantly by intra-uterine death indicated by a macerated fetus, prematurity, and with cause unknown, the total being 36 or approximately 3 per 1,000.

SUMMARY

There have been 9 maternal deaths or less than 1 per 1,000; 49 full term newborn deaths or less than 5 per 1,000; 2,091 spontaneous deliveries or 22 plus per 1,000; 379 cesarean sections, approximately 4 per 1,000; 6,889 elective forceps deliveries, or 750 per 1,000; 378 breech presentations, or 4 per 1,000; 78 multiple pregnancies, or less than 1 per 1,000; 493 tube sections, or 5 plus per 1,000; 609 lacerations of perineum or 6 plus per 1,000; 7,046 episiotomies or 750 plus per 1,000; 9 versions and extractions, which does not include version and extractions of the fetus in multiple pregnancy, or less than 1 per 1,000; and 8 cases of eclampsia or less than 1 per 1,000.

COMMENT

This report is made possible by the thorough coöperation of a group of physicians who consulted freely on every case of difficulty without any thought of remuneration and with total disregard of the violation of ethical procedure. Each member of this group was happy to care for the patients of any other member of the group during prenatal and lying-in periods as well as in delivery and postpartum recovery. It is obvious that professional men deeply interested in the welfare of the patient may work together in harmony and to the advantage of the patient and attending physician.

Dr. Beavers: 1408 Pennsylvania.
Dr. Bennett: 650 S. Henderson.
Dr. Grogan: 921 Fifth Avenue.
Dr. Hiett: 603 College.

ABSTRACT OF DISCUSSIONS

Dr. John Dale Weaver, Austin: After visiting the hospital where these obstetricians work, I could not refrain from asking for the presentation of this report. It is a definite inspiration to see these four men do the work they do with so many patients and so little help. They do excellent work and the spirit of the Hippocratic oath is well exemplified in their association and services rendered to the patient.

Dr. Nicholson J. Eastman, Baltimore: I have nothing but praise for the results achieved and the policy followed. Let it be noted that the fetal mortality reported reached an almost irreducible minimum.

In 1936 there was quite a debate on the question of analgesia at the American Medical Association meeting in Kansas City.

What in past years has been the most common cause of stillbirths and neonatal deaths? What has been the most common cause of obstetrical hemorrhage? The injudicious use of forceps certainly helped. I recall the days when amnesic drugs were not used. The everlasting crying and pleading for help by the patient led the physician to put on the forceps before he should have. Amnesic drugs rather than having a harmful effect, have a beneficial effect, and this report has borne that out. I was impressed by the tubal ligation referred to in the report. We do a good deal of them in Baltimore. In teaching institutions we find it desirable to use rigid standards. We have done 700 to 800, and we do them early, that is, the first twenty-four to forty-eight hours. We have had no failure, either. I would like to tell my understanding of the terms Madlener and Pomeroy. I am not sure I am right, but there is a distinct difference in the recommendations of those authors and a difference in results. In the

Madlener procedure the tube is crushed and a nonabsorbent suture is used (silk-worm or cotton). That is all I think is done—nothing is cut away. The Pomeroy method is characterized by omission of crushing, taking up a loop, and with absorbable suture (0 to 00) getting the gut and tying the tube to form a knuckle sticking up. The knuckle is cut below the loop to leave two separate ends. The technique is similar, but the principle is different. When they were operated on two to three years later for other reasons, we found the Madlener patients showed the tube stuck together in the place of procedure and the lumen obliterated. The Pomeroy patients looked entirely different later in that the ends of the tube were pulled apart for about .5 to .75 inches and covered with fibrin. In other words, with all nonabsorbent sutures in the Madlener, the ends stay together, and in a Pomeroy, with all absorbent sutures plus cutting of the knuckle, the ends are allowed to draw apart. Out of 125 Madlener procedures I have seen 5 failures and in 700 Pomeroy operations done by interns, assistant residents, and younger men in general, to my knowledge there has not been a single failure. If there is a failure, the patient comes back in a good deal of a huff pretty readily.

Dr. Grogan, closing: I want to thank Dr. Eastman for his illuminating remarks on technique. We did not mean to confuse the two. What we use might be called the Madlener procedure with the Pomeroy section of the tube.

HOW INNOCENT IS THE ORDINARY NONPIGMENTED MOLE?

CHARLES PHILLIPS, M. D.
TEMPLE, TEXAS

In the routine work of a rather large service in surgical pathology there has stood out in recent years a group of melanomas so destructive that they have challenged special attention. There is nothing new about this, for medical writings on this subject over a period of fifty years are numerous and it is common knowledge that the victim of a melanoma does not have too much chance by the time he presents himself to his physician. There is a smaller group of less well known melanomas which are not pigmented and yet are equally as dangerous as the pigmented ones, and it is this group about which I am concerned. They are simply called nonmelanotic melanomas and bear the same relationship to nonpigmented moles that ordinary melanomas do to pigmented moles. So that the same process will be considered, a few simple definitions are in order.

When one considers the term "mole," he finds confusion as to its meaning and naturally asks the author of a paper on this subject to clarify himself. The word "mole" is not a good one, and if there is disagreement with this statement, investigation of the subject, using dictionaries, texts on histology, pathology, and dermatology, and the applied writings of those who have worked on this subject is suggested. The word "nevus" in place of "mole," particularly in regard to neoplasms derived from such cutaneous lesions, will probably be acceptable. I am not disposed to go into the evolution of the theories as to what constitutes a nevus, but the value of the patient and careful investigations of students like Masson, whose work tends to show the specific nervous origin and nature of nevus cells and their relationship to certain tumors now by some called "melanoma" or "nevocarcinoma," should be admitted. These histological studies have helped all concerned to consider anew the nevus cell and its relationship to pigment production. The term "melanoblast" is definite and the cell of that name does or does not make melanin pigment according to the activity of a specific enzyme. Bloch[3] and his group call this substance dopa-oxydase and assign it a chemical name of 3-4 dioxyphenylalinine, and now pathologists can use the dopa reaction in pigmented tumors to help identify the source and activity of specific cells. Thus, today it is possible to talk of the mole as a nevus and, if accuracy is maintained, to visualize the nevus cells in cutaneous lesions and remember that with or without pigment they are essentially the same. This definition would exclude so-called "vascular nevi." It would narrow the field of study but make the work more accurate.

It is common knowledge that moles or nevi are present in the skin of so many people that most pathologists are inclined to regard them as simple unless they get in the way, are disfiguring, and begin to grow in size. There are not many recorded systematic surveys of mole counts on groups of people, but Pack has given one figure of twenty moles per person in a study of 300 individuals. To be realistic, one should state what is included in such counts, for even the little dark-brown pigmented spot so common to many should be defined. In our work at Scott and White Clinic we have not attempted any systematic counts, but experience backs the statement that most people have multiple moles or nevi. If excision of any is done, then histologically they are classified for this purpose as pigmented or nonpigmented nevi. I recall 2 women patients who had over 200 such lesions each. The presence or absence of hair does not seem to make any difference except as to the greater possibility of irritation if the mole is hairy. Some controversy has occurred as to the status of "congenital" or "acquired." I find many intelligent patients not at all certain about the duration of their nevi and who frequently reply "all my life" when

From the Department of Surgical Pathology, Scott and White Clinic.
Read before the Section on Clinical Pathology, State Medical Association of Texas, Annual Session, Galveston, May 7, 1946.

asked how long the nevi have been present. There is no doubt that competent observers have recorded the known growth of moles in skin areas previously free from them.

Nevi or moles are found on almost every part of the body. They are rare on the palmar surfaces of hands and feet but are well known between fingers and toes, a fact given much significance by some writers on melanoma. Naturally, hairy nevi and those about the face, head, and neck are more easily observed; but our experience has been that derived melanomas, pigmented or nonpigmented, have been found at sites quite widely distributed over the body surface. I believe that many nevi simply grow in size with the growth of the person and that adult patients want something done about them largely because they are unsightly or have become irritated. Thus attention is paid to them.

It is the independent growth which is significant and which, if unchecked, frequently leads to disaster. The person having a mole of any form which is subject to friction or irritation of any type is likely to become aware of changes in the condition of the process and call the attention of his doctor to it. Such irritations are brought about by rubbing of underclothing, suspenders, belts, garters, shoes, collars, combs, and brushes and by shaving and the cutting of hair by a barber or a hair dresser. At first the owner of the mole is aware of the friction because of tenderness and redness. To this there may be added infection and increase in size of the growth; and here is nature's warning, which is all too frequently somewhat ignored by patient and physician. From the abundance of readily accessible information the doctor at least ought to know that a mole is made up of cells which can develop into the dread melanoma and that the simple nonpigmented mole may be equally as dangerous as the brown mole. Those of us who handle many cases of this type are impressed that apparently a good many doctors do not realize the gravity of the situation, for they treat nevi lightly by simple excision to a level, by electric needles, by electrodesiccation, by chemical pastes, by roentgen ray or radium. No pathologist would contend that some nevi could not be destroyed by such simple methods, but the same pathologist would assert that the patient was lucky, for nevus cells frequently go rather deeply below the skin and superficial treatment would remove only part of the danger. In the light of repeated warnings over the past fifty years about the seriousness of this situation there is no excuse for such ignorance by physicians, but now and then I see patients lose their lives because some doctor paid no attention to this danger.

The nevus or mole is simply a local aggregation of nevus cells which live just below the basal layer of the skin and which according to their number give rise to a tumor at this place. These rounded nevus cells can produce melanin or not. If they do, the growth is brown or pigmented; but, if not, the growth is simply the "white mole" or nonpigmented mole. The thing to remember is that the significance of one cell is as great as that of another and that the only adequate cure is complete removal at one operation. A growing mole spreads locally by hyperplasia and extends outward and downward. When malignant transformation occurs, spread is local as well as metastatic by lymphatics and blood stream. We have known the seemingly local nonmelanotic melanoma to be the source of metastases when by ordinary standards of tumor study the growth would be considered entirely local. In examining nevi in great number we become aware of considerable variation in structure, in the number and size of cells, in their position in reference to structures proper to the area, such as skin covering, hair, and sweat and sebaceous glands, in extent of lateral spread and growth downward, and in the presence or absence of melanin. Here, as in all pathologic studies, experience is necessary, but it is quite possible to classify derived melanomas into kinds and degrees of malignancy just as is done in epitheliomas. In general the biological significance of grading melanomas is the same as in other neoplasms, differentiation being the measuring device. Some students[2] of this problem maintain that the function of a melanoblast is to produce melanin and therefore the nonmelanotic melanoma is simply a more undifferentiated growth[4] and as a consequence is more to be feared. I am not entirely convinced of the accuracy of this viewpoint, but at least we have in our files many cases of patients with nonmelanotic growths which spread rapidly and fatally. One fact causing confusion to some is that metastatic growths from primary sites which are pigmented may show little or no pigment. The opposite is also true, but in our experience the ordinary nonpigmented mole going over into melanoma is likely to produce nonpigmented metastases with fairly dependable regularity. This variability in behavior of cells of metastatic melanoma also makes it difficult to identify the nature or appearance of the original mole excised by the doctor when its nature was not recorded. It is frequently necessary to work backward from metastasis to original

site of the mole and find that the patient or the physician is quite vague or indifferent to something as seemingly innocent as an ordinary mole. Sometimes unusual diligence in search and questioning gives no idea as to the primary site of the cells now slowly killing the patient.

From what I have written thus far it is plainly seen that I am concerned over the failure of doctors to recognize the significance of the ordinary mole, and it is fair to ask the question as to what to do about it. The answer as to treatment naturally falls into two parts, prophylactic and therapeutic. Many distinguished dermatologists and surgeons since the turn of the century have advised that the profession fully acquaint itself with this whole question and carry out prophylactic removal of moles from sites of irritation. As the years have gone on collected series of melanomas have become larger in size and the data more accurate, and the advice of authors is even more insistent that the doctors wake up and do a better job. W. W. Keen in 1904[7] urged that this be done. One of the large series of melanomas is reported by Adair,[1] who in 1936 insisted again that physicians use diligence in removing moles before they become malignant. It is manifest that common sense will have to be used, but it is a safe general rule to excise widely all moles or nevi at friction sites about the body and to do so at one operation. Unless the whole thickness of the skin is removed it may be futile because of the position of nevus cells already described. Regarding therapy of malignant tumors derived from nevi there is rather wide division of opinion as to technique but not as to thoroughness of local removal by wide excision. The results of straight surgical removal versus irradiation are definitely in favor of radical surgery. Many prefer a combination of surgery and roentgen ray, for it appears to be agreed that melanoma cells of whatever habits of pigment formation are rather radioresistant. I recently saw a mass of metastatic melanoma in lymph nodes which had been heavily irradiated, and, although there was considerable evidence of irradiation necrosis, there were many areas of undamaged tumor cells close by. I am convinced that, if we are to advance our recovery data, we must be radical and courageous. As far back as 1894 Hutchinson,[6] writing on "Melanosis from Moles," stated:

"It is surely quite needless to point out that the proper treatment of an inflamed or irritated mole is immediate and free excision. On no account should any temporizing measures be tolerated. The patient's only chance of safety consists in excision of the whole thickness of the skin with a very wide margin. It is much to be desired that all members of the profession should have their minds fully alive to the features presented by these cases and the terrible results of loss of time. It is in the hope of impressing this lesson that I have thought it worth while to publish this portrait."

In our clinic we practice wide and deep excision and use the electric cautery to perform the operation. In selected cases block dissection of regional lymph nodes has been carried out, and we believe that this has at least prolonged the lives of some patients and probably contributed to the cure of others.

What results can be expected in handling cases of nonmelanotic melanoma following malignant changes in an ordinary nonpigmented mole? An answer to this would have to be qualified by the clinical condition of the patient, taking into consideration the location, duration of the lesion, age of the patient, presence or absence of metastasis, whether primary or recurrent, and the whole problem of operability, which naturally brings into consideration the judgment and skill of the operator and the technique used. In medical literature of the past fifty years there are not too many data on the nonmelanotic melanoma itself, for consideration of this type of neoplasm is merged into the general question of melanoma. In 1928 Horwitz[5] traced 44 of 49 patients and found 88.6 per cent dead. In 1936 Adair[1] reported 8.74 per cent five-year survivals. In general the chances of recovery are poor unless the lesion is early and well handled.

It is not the purpose of this paper to stress the melanoma as much as it is to emphasize the relationship between the ordinary nonpigmented mole and the nonmelanotic melanoma. To that end I have picked out a group of 27 tumors of this type occurring in a group of 165 melanomas, and thus occurring as 16.3 per cent of the whole, seen at Scott and White Clinic in the past twenty-five years. There have been several other cases seen during this time, but data on them are inadequate and so they are not included in this series. During this time we have closely studied 1,280 nevi excised for biopsy.

In this series of nonmelanotic melanomas males predominate in the ratio of 17 to 10, but records show that women have as many moles as men. Perhaps it is true that men with moles more frequently injure them, and certainly trauma to preexisting moles of any kind is well known as a factor in starting the seemingly innocent lesion to growing.

As to age incidence, the second and eighth decades have only one patient each in them while the age group of 60 to 69 years is in the lead with 40 per cent of the patients. This classification as to age is, as one readily sees, not too valuable, for the number of pa-

tients is too small; but it should be pointed out that the average age of persons having ordinary skin cancer approaches the same age groups. The patient or the physician may easily confuse the two lesions.

It has been interesting to grade these nonpigmented melanomas as to their degrees of malignancy, using the ordinary 1-to-4 method of Broders. Three cases were grade 1; 12 were grade 2; 7 were grade 3; 2 were grade 4; 1 was ungraded; and 2 had several grades given their lesions because they gradually became more malignant as the tumors progressed. Of these 2, one melanoma started on the arm as a grade 2 and over the succeeding eight years grew more malignant until shortly before death the last tissue studied was of grade 4. The other patient with multiple gradings had a simple grade 1 on the face and in three years returned with a grade 4 in metastasis, which under cautery excision may have been cured, for the patient lived three more years to die of apoplexy in arterial hypertension. Of the 8 known melanoma deaths in this series of 27 patients, none followed grade 1 lesions; 4 followed grade 2; 3 followed grade 3; and 1 followed grade 4. In this summation the grades given refer only to primary grades given to the tumors.

In the 27 melanomas there were 5 other known deaths: 3 from hypertensive heart disease, 1 from cancer of the prostate, and 1 from cause unknown. Some of the patients lived long enough to develop cancer of other organs, but in only 1 instance was this a known cause of death.

We found that, just as in other malignancies, if patients reported with recurrent or metastatic lesions, their chances of survival were not too good. This is not always true, for the longest survival in the series had two local recurrences before a radical gland dissection helped to stop the disease. These nonmelanotic melanoma cells do not behave any more nor any less regularly than cells of other cancers, and frequently there are rather surprising periods of latency between removal of growths and their metastases or final death from melanoma.

We have been able to trace 67.5 per cent of these patients up to now and know about all but 4. One of these was treated twenty-four years ago and within two months was reported as having a recurrence. If the trend of other recurrent grade 2 tumors of this group held, this patient probably died of melanoma. A second patient was not treated by us but only seen in consultation, for she then had multiple subcutaneous metastases following a primary growth on her foot. This tumor was the only one in the entire series not graded. The patient probably died of melanoma. The other 2 untraced cases were treated in the past six months, and their present status is unknown.

There are alive and well now 3 patients treated within the year. There are 7 patients alive and well for from two to fifteen years, and 1 of these had a metastatic deposit. It is unwise to draw too hard and fast conclusions about these patients so recently treated, but at least it can be said that grade 1 nonmelanotic melanomas can be cured with wide local excision with or without regional gland dissection. Grade 2 lesions are more difficult to cure and tend more often toward recurrence or metastasis. Patients with grade 3 and grade 4 tumors stand a poor chance of cure or even survival beyond a year or two, and frequently treatment is of no avail.

Discounting the 4 patients listed as untraced, 2 of whom probably died of melanoma, it will be found that of 23 persons in the group with nonmelanotic melanoma accounted for up to now 8, or 34.7 per cent, are known to have died of this disease while 10, or 43.5 per cent, are living and well. Some of the latter have been treated only within the year, and it is probably too soon to report them otherwise. There are 4 five-year cures in the whole series, giving 14.8 per cent of this type of survival. This itself emphasizes the serious nature of a neoplasm derived from simple nonpigmented moles.

SUMMARY

In handling a large number of tumors involving the skin I have become increasingly aware of the need of better handling of the ordinary nonpigmented mole and have presented a group of melanomas derived from such lesions. When it is realized that patient after patient loses his life because patients and doctors alike have failed to recognize the potential danger in moles or nevi and have inadequately treated them, it is easier to remember repeated warnings in medical writings over the past fifty years. I wish to repeat that studies on the ordinary simple nonpigmented mole and its tumor derivatives prove that moles at irritation sites about the body should be removed by surgical excision with wide margin and at one operation. Less than that is dangerous. The answer to the question at the beginning of this paper is definitely that the ordinary nonpigmented mole is not innocent.

REFERENCES

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4. Farrell, H. J.: Cutaneous Melanomas, Arch. Dermat. & Syph. 26:110 (July) 1932.
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6. Hutchinson, J.: Melanosis from Moles, Arch. Surg. 5:125, 1894.
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ABSTRACT OF DISCUSSIONS

Dr. A. O. Severance, San Antonio: I imagine it is the custom of the average pathologist to designate a mole or nevus as amelanotic or nonpigmented if he is unsuccessful in demonstrating pigment in the tumor cells using ordinary hematoxylin and eosin slides. Stout of New York, however, uses the term amelanotic only if he fails to find pigment in the tumor cells after careful search in a Fontana silver preparation. As Dr. Phillips points out the "dopa" reaction is of value in proving the diagnosis of an amelanotic malignant melanoma. At present with the shortage of technical help most of us will have to make the diagnosis of moles and melanomas on hematoxylin and eosin slides.

I wish to emphasize all that Dr. Phillips has said about treatment of moles and again to urge surgical excision with a safe margin. This allows complete removal of the mole and when it is examined microscopically the safety of margin of the excision is checked and a correct diagnosis rendered. I also realize that the dermatologists will take issue with this point of view. Block dissection of regional nodes done prophylactically has much to warrant attention.

It has not been my custom to grade malignant melanomas but I agree that some look more malignant than others. The poor prognosis of these tumors —pigmented or not—is well known to all.

We are indebted to Dr. Phillips for calling our attention to the importance of the nonpigmented mole and its proper treatment.

Dr. Marvin D. Bell, Dallas: I certainly heartily agree with Dr. Phillips regarding the seriousness of these lesions. I am surprised, however, at the number of long time cures which he reports. I am accustomed to see the distant metastasis from nevi occur from one to three or four years after removal of a supposedly innocent nevus; but after the metastasis has appeared, one year is a long time for the patient to survive.

MISCELLANEOUS

COMING MEETINGS AND CLINICS

State Medical Association of Texas, Dallas, May 5-8, 1947. Dr. C. C. Cody, Jr., Houston, President; Dr. Holman Taylor, 1404 W. El Paso St., Fort Worth 3, Secretary.

American Medical Association, Atlantic City, N. J., June 9-13, 1947. Dr. Harrison H. Shoulders, Nashville, Tenn., President; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secretary.

Southern Medical Association, November, 1947. Dr. E. L. Henderson, Louisville, Ky., President; C. P. Loranz, Empire Building, Birmingham, Ala., Secretary-Manager.

Southwest Allergy Forum, Shreveport, La., March 31-April 1, 1947. Dr. W. H. Browning, Shreveport, La., President; Dr. Sim Hulsey, Medical Arts Bldg., Fort Worth, Secretary.

Texas Association of Medical Anesthetists, Dallas, May 5, 1947. Dr. Claudia Potter, Temple, President; Dr. Russell Bonham, Box 6237, Houston, Secretary.

Texas Association of Obstetricians and Gynecologists, Fort Worth, November, 1947. Dr. J. E. Kanatser, Wichita Falls, President; Dr. Julius McIver, 714 Medical Arts Building, Dallas, Secretary.

Texas Chapter, American College of Chest Physicians, May 5, 1947. Dr. R. G. McCorkle, San Antonio, President; Dr. Elliott Mendenhall, 1217 Medical Arts Bldg., Dallas, Secretary.

Texas Club of Internists. Dr. Alvis E. Greer, Houston, President; Dr. Julian C. Barton, 414 Navarro St., San Antonio, Secretary.

Texas Hospital Association, Houston, March 27-29, 1947. Tol Terrell, Harris Memorial Methodist Hospital, Fort Worth, President; Mrs. Ruth Barnhart, 2210 Main St., Dallas, Secretary.

Texas Neuropsychiatric Association, Dallas, May 5, 1947. Dr. Fred T. Rogers, Dallas, President; Dr. David Wade, 604 Capital National Bank Bldg., Austin, Secretary.

Texas Orthopedic Society. Dr. E. A. Cayo, San Antonio, President; Dr. Edward Smith, 1215 Walker Ave., Houston, Secretary.

Texas Pediatric Society, Houston, October, 1947. Dr. J. R. Lemmon, Amarillo, President; Dr. John E. Ashby, 3610 Fairmount, Dallas, Secretary.

Texas Public Health Association. Dr. L. P. Walter, Austin, President; Mr. Earle W. Sudderth, Dallas County Health Department, Court House, Dallas, Secretary.

Texas Radiological Society. Dr. C. A. Stevenson, Temple, President; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secretary.

Texas Railway and Traumatic Surgical Association, May 5, 1947, Dr. F. L. Snyder, Fort Worth, President; Dr. Ross Trigg, First National Bank Bldg., Fort Worth, Secretary.

Texas Society for Mental Hygiene, San Antonio, April 10-12, 1947. Dr. Jack R. Ewalt, University of Texas Medical Branch, Galveston, President; Mrs. Elizabeth F. Gardner, 1617 Watchhill Road, Austin 21, Executive Secretary.

Texas Society of Gastro-Enterologists and Proctologists, Dallas, May 5, 1947. Dr. Tom E. Smith, Dallas, President; Dr. D. L. Curb, 704 Dallas Ave., Houston, Secretary.

Texas Society of Ophthalmology and Otolaryngology, Houston, December, 1947. Dr. W. E. Vandevere, El Paso, President; Dr. E. D. Dumas, 425 Medical Arts Bldg., San Antonio, Secretary.

Texas Society of Pathologists, Business Session, Dallas, May 7, 1947; Annual Session, Galveston, January 25, 1948. Dr. D. A. Todd, San Antonio, President; Dr. C. T. Ashworth, Southwestern Medical College, Dallas, Secretary.

Texas State Heart Association, Dallas, May 5, 1947. Dr. Robert M. Barton, Dallas, President; Dr. M. B. Whitten, Medical Arts Bldg., Dallas, Secretary.

Texas State Urological Society, Dallas, November or December, 1947. Dr. Jo C. Alexander, Dallas, President; Dr. Hub Isaacks, Medical Arts Bldg., Fort Worth, Secretary.

Texas Surgical Society, Dallas, April 7-8, 1947. Dr. Walter Stuck, San Antonio, President; Dr. Truman G. Blocker, University of Texas Medical Branch, Galveston, Secretary.

Texas Tuberculosis Association, Dallas, September 15-16, 1947. F. K. Dougharty, Liberty, President; Miss Pansy Nichols, 700 Brazos, Austin, Executive Secretary.

Third, Panhandle, District Medical Society, Amarillo, April 8-9, 1947. Dr. W. A. Carroll, Claude, President; Dr. George Powers, Fisk Bldg., Amarillo, Secretary.

Fourth District Medical Society, Coleman, 1947. Dr. Glenn H. Ricks, Brady, President; Dr. J. C. Young, Coleman, Secretary.

Seventh, Austin, District Society, Austin, March 6, 1947. Dr. Robert B. Morrison, Austin, President; Dr. M. I. Brown, Capital National Bank Bldg., Austin, Secretary.

Eighth, Ninth and Tenth Districts Medical Society, Orange, April, 11-12, 1947. Dr. Walter F. Hasskarl, Brenham, President; Dr. George W. Waldron, Medical Arts Bldg., Houston, Secretary.

Eleventh District Society, Tyler, March 14, 1947. Dr. L. L. Travis, Jacksonville, President; Dr. C. B. Young, 929 S. Confederate, Tyler, Secretary.

Twelfth, Central Texas, District Society, Marlin, July 8, 1947. Dr. W. Howard Wells, Waco, President; Dr. H. F. Connally, Jr., Amicable Bldg., Waco., Secretary.

Thirteenth, Northwest District Society, Abilene, April 22, 1947. Dr. Frank Hodges, Abilene, President; Dr. Robert C. Stokes, 501 First National Bank Bldg., Fort Worth, Secretary.

Fourteenth District Society, Sherman, June, 1947. Dr. H. Frank Carman, Dallas, President; Dr. James Jeter, Ennis, Secretary.

Fifteenth, Northeast Texas, District Society, Gilmer, Fall, 1947. Dr. Joe Robérts, Longview, President; Dr. S. W. Tenney, Marshall, Secretary.

CLINICS

Dallas Southern Clinical Conference, Dallas, March 17-20, 1947. Miss Thelma J. Webb, 1133 Medical Arts Bldg., Dallas 1, Executive Secretary.

HOSPITALS NEEDING INTERNS AND RESIDENTS

Methodist Hospital, Dallas. Capacity 206 beds. C. B. Fielder, Superintendent (interns desired, July, 1947).

El Paso City County Hospital, El Paso. Capacity 192 beds. George W. Cook, Col., U. S. A., Ret., Superintendent (3 interns for one year term, graduates of class A medical school only).

All Saints Episcopal Hospital, Fort Worth. Capacity, 110 beds. Approved for graduate residency. Eva M. Wallace, R. N., Superintendent (1 resident immediately; 2 by July 1).

MEMBERS OF THE FIFTIETH TEXAS LEGISLATURE

The names of Senators and Representatives in the Fiftieth Legislature of Texas are listed below by districts for the convenience of those who wish to contact them in connection with the current legislative program of the State Medical Association and of other groups interested in improving health conditions in the state.

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7.	Thomas Harris Sharp	Beckville
8.	Joe B. Fleming	Henderson
9.	Jewell Helpinstill	Nacogdoches
10.	C. G. Lightfoot	Timpson
11.	Paul S. Wilson	Geneva
12.	Ottis E. Lock	Lufkin
13.	Edward P. Hughes, Jr.	Newton
14.	David Read	Silsbee
15f.	Miller B. Walker	Beaumont
16.	Jack B. Brooks	Beaumont
	Otis Lee	Port Arthur
17f.	Louie D. Godard	Texas City
18.	Donald M. Markle	Galveston
19.	Charles A. Murphy, Jr.	Houston
	Carlton Moore, Sr.	Houston
	Searcy Bracewell	Houston
	J. M. Heflin	Houston
	William A. (Bill) Miller, Jr.	Houston
20.	J. F. Ward	Rosenberg
21.	Carlton Crawford	Palacios
22.	Lloyd M. Guffey	Wharton
23.	Marvin D. Fertsch	Hallettsville
24.	J. A. Luedemann	Brenham
25.	C. S. McLellan	Eagle Lake
26.	W. T. (Bill) Moore	Bryan
27f.	Mrs. Neveille H. Colson	Navasota
28.	Lesta Shackelford	Livingston
29.	M. B. Etheredge, Jr.	Huntsville
30.	J. B. Sallas	Crockett
31.	Pat Wiseman	Jacksonville
32.	Bill Wood	Tyler
33f.	F. G. Swanson	Tyler
34.	Miss Elizabeth Suiter	Winnsboro
35.	Alford H. Flanagan	Talco
36.	Grady Moore	Clarksville
37.	George W. Watson	Paris
38f.	John Ford	Paris
39.	E. O. Chapman	Sulphur Springs
40.	Fred J. Jones	Lone Oak
41.	Ray Kirpatrick	Trenton
42f.	J. O. Berry	Commerce
43.	Davis Clifton	McKinney
44.	James T. (Jim) Sparks	Sherman
	Sidney McClain	Sherman
45f.	Roger Q. Evans	Denison
46.	C. C. Gardner	Gainesville
47.	Wayne W. Waggonseller	Fruitland
48.	L. C. Slimp, Jr.	Decatur
49.	Robert Hal Jackson	Denton
50.	John L. Crosthwait	Dallas
	W. O. Reed	Dallas
	Sam Hanna	Dallas
	George Parkhouse	Dallas
	Dallas A. Blankenship	Dallas
51f.	Preston Mangum	Dallas
52.	Phillip L. Willis	Kaufman
53.	M. K. Thomas	Wills Point
54.	James C. Spencer	Athens
55.	A. J. (Jack) Overton, Jr.	Palestine
56.	Gus M. Lanier	Marquez
57.	Elmer McVey	Teague
58.	George O. Nokes, Jr.	Corsicana
59.	Andy M. James	Hillsboro
60f.	Jerry T. Stockard	Frost
61.	A. R. (Robin) Henderson	Groesbeck
62.	Frank C. Oltorf, Jr.	Marlin
63.	Herman Yezak	Bremond
64.	A. N. Green	Cameron
65f.	Henry G. Lehman	Giddings
66.	R. B. Spacek	Fayetteville
67.	Durwood Manford	Smiley
68.	John J. Bell	Cuero
69.	William S. Fly	Victoria
70.	H. L. Atkinson	Beeville
71.	O. E. Cannon	Corpus Christi
72.	Augustine Celaya	Brownsville
73.	Joe M. Kilgore	McAllen
74.	Sam G. Reams	Falfurrias
75.	Abraham Kazen, Jr.	Laredo
76.	Donald Peters	Cotulla
77.	Britton T. Edwards, Jr.	LaPryor
78.	W. A. (Cap) Williamson	San Antonio
	Eugene C. Williams	San Antonio
	Jack F. Ridgeway	San Antonio
	Marshall O. Bell	San Antonio
	O. E. Latimer	San Antonio
79.	L. L. Holstein	Pandora
80.	H. A. Heideke	Seguin
81.	William George Richards	Lockhart
	Max C. Smith	San Marcos
82.	J. Pearce Johnson	Austin
	Obie Jones	Austin
83.	Frank Svadlenak	Thrall
84f.	William R. Stump	Georgetown
85.	Tom Martin	Fredricksburg
86.	C. H. Gilmer	Rock Springs
87.	Charles B. Moore III	Del Rio
88.	George Elliott	Odessa
89.	S. J. Isaacks	El Paso
	William S. Jameson	El Paso
90f.	Woodrow W. Bean	El Paso
91.	R. E. Blount	Big Spring
92.	W. H. Rampy	Winters
93.	Reuben E. Senterfitt	San Saba
94.	Sid Gregory, Jr.	Gatesville
95.	Lamar Zivley	Temple
96f.	Sam C. Sellers	Waco
97.	Gordon Davis	Waco
	J. K. Aynesworth	Waco
98f.	Albert M. Jones	Valley Mills
99.	D. D. Gathings	Cleburne
100.	Mrs. Rae Files Still	Waxahachie
	Don A. Lewis	Midlothian
101.	Joe Pyle	Fort Worth
	W. H. (Bill) Abington	Fort Worth
	Doyle Willis	Fort Worth
	John L. (Red) Wallace	Fort Worth
102f.	Warren C. Cowen	Fort Worth
103.	Jim Wright	Weatherford
104.	W. E. Heatly	DeLeon
105.	J. W. (Bill) Shannon	Stephenville
106.	T. M. Collie	Eastland
107f.	L. R. Pearson	Ranger
108.	Jack Cox	Breckenridge
109.	N. F. (Dick) Smith	Jacksboro
110.	Jimmy P. Horany	Archer City
111.	C. M. McFarland	Wichita Falls
	Vernon McDaniel	Wichita Falls
112f.	Leslie King	Harrold
113.	Charles M. Conner	Haskell
114.	Claude Calloway	Crowell
115.	William B. Teague	Anson
116.	W. K. (Bill) Tippen	Abilene
117.	Harley Sadler	Sweetwater
118.	Sterling Williams	Snyder
119.	Preston E. Smith	Lubbock
120.	I. B. Holt	Olton
121.	Sheffy Mahan	Childress
122.	R. L. Templeton	Wellington
123.	J. Blake Timmons	Amarillo
124.	William J. (Bill) Craig	Miami
125.	Charles L. South	Coleman
126f.	Joe W. Gandy	Winnsboro
127.	Harry Whitworth	Smithville

MEDICAL OFFICERS RETURNING TO TEXAS*

(Corrections: Harvey K. Jackson has returned to Amarillo instead of Dallas; Robert W. Talley, listed at Houston, is still in service with the Navy.)

NAME	Serv.†	Location	Release Date
Bell County			
21. Christian, John J.	A	Temple	
Bowie County			
7. Pirkey, Will P.	N	New Boston	
Brazos-Robertson Counties			
10. Waller, Alvin L.	A	Bryan	
Coleman County			
5. Finney, James W.	A	Coleman	
Crane-Upton-Reagan Counties			
2. Irvine, George N., Jr.	A	McCamey	
Dallas County			
248. Behrman, James M.	A	Dallas	
249. Cole, Charles M.	A	Dallas	
250. Evans, Edward L.	N	Dallas	
251. Fife, Ray	A	Dallas	
252. Henry, David J.	N	Dallas	
253. Love, Horace G., Jr.	N	Dallas	
254. Nelson, Albert D., Jr.	N	Dallas	
255. Smith, Ralph C.	N	Dallas	
Eastland-Callahan Counties			
8. Jackson, Claude L.	A	Ranger	
El Paso County			
73. Tanaka, Paul A.	A	El Paso	
Galveston County			
66. Brucer, Marshall H.		Galveston	
67. DeMesquita, Paul J. B.	N	Galveston[1]	
68. Renfert, Henry J.	N	Galveston	
69. Skripka, Charles F.	N	Galveston	
Gray-Wheeler Counties			
12. Kelley, Frank W.	A	Pampa	
Grayson County			
16. Gleckler, William J.	N	Sherman	
17. Petty, Tom A.	A	Sherman	
18. Rutledge, Art H.	N	Denison	
Grimes County			
5. Thompson, Hardy E., Jr.	N	Navasota	
Harris County			
292. East, Norman R.		Houston	
293. Kaplan, Leland	N	Houston	
294. Theriot, Joseph R., Jr.,	A	Houston	
295. Wagner, Robert G.	A	Houston[2]	
Hidalgo-Starr Counties			
15. Hoffmaster, V. D.	A	Edinburg[1]	Dec., 1946
Kerr-Kendall-Gillespie-Bandera Counties			
15. Bell, William E.	A	Kerrville	
Kimble-Mason-Menard-McCulloch Counties			
7. Hays, Jack R.	N	Brady	
Lampasas-Burnet-Llano Counties			
6. Hunter, Thomas R., Jr.	N	Lampasas	
Lavaca County			
8. Plageman, William H.	N	Shiner	
Lubbock-Crosby Counties			
32. Mast, Clarence S., Jr.	N	Lubbock	
33. Payne, Glen B.	N	Lubbock	
McLennan County			
55. Cohenour, Robert E.	A	Waco	
56. Dean, Earl F., Jr.	N	Waco	
57. Gordon, Clarence E.	A	Eddy	
58. Marstaller, W. E.	A	Waco	
Nacogdoches County			
7. Beall, James Frank	A	Nacogdoches	Mar., 1946
Nolan-Fisher-Mitchell Counties			
12. Bessire, Milton C.		Hamlin	
Pecos-Jeff Davis-Presidio-Brewster Counties			
6. Cartall, Louis M.	N	Marfa	
Potter County			
33. Hatchett, Capres S., Jr.	A	Amarillo	
34. Wheir, W. S.		Amarillo	
Randall-Deaf Smith-Parmer-Castro-Oldham Counties			
7. McLean, William F.	N	Hereford	
Rusk County			
12. De Young, Richard	A	Overton	
Smith County			
19. Castle, Charles W.	N	Troup	
Tarrant County			
93. Austin, Carl M.	A	Fort Worth	
94. Isbell, Marney C.	A	Fort Worth	
95. Terrell, C. O., Jr.		Fort Worth	
Taylor-Jones Counties			
24. Gibson, J. P.	A	Abilene	
25. McDonald, Donald H.	A	Abilene	Jan., 1946
26. Magee, Jefferson D., Jr.	A	Abilene	
Titus County			
3. Ellis, John M., Jr.	A	Mount Pleasant	
Tom Green-Coke-Crockett-Concho-Irion-Sterling-Sutton-Schleicher Counties			
25. Thompson, Chase S.	A	San Angelo[2]	May, 1946
Travis County			
73. Neighbors, Allan H., Jr.	N	Austin	
Wichita County			
28. Smith, Harry S.	A	Wichita Falls	
Williamson County			
9. Rice, Albert J.		Georgetown	

*EDITOR'S NOTE: This list is the sixteenth of a series in which it is hoped to name all those physicians who have been in the Armed Forces during the war recently passed and have now returned to Texas to resume civilian practice. The information in this list has been assembled from a variety of sources. While an attempt has been made to secure as complete and as accurate data as possible, we are aware that omissions and errors have been made. Not only for publication in the JOURNAL but also for the permanent records in the central office of the State Medical Association, we invite and urge correction of and addition to the material here submitted. Note that physicians from each county area are numbered consecutively following those listed in the January JOURNAL; the last number in each section therefore indicates the total physicians returned to that county area. The complete total for Texas named to date (February 25), including the accompanying list, is 2,067.

†A=Army; N=Navy; U=U. S. Public Health Service.

[1]Formerly of Orange.

[2]Formerly of Cuero.

[1]Formerly of Dallas.

[2]Formerly of Lubbock.

TEXAS SOCIETY FOR MENTAL HYGIENE

The annual conference of the Texas Society for Mental Hygiene, to be held in San Antonio, April 10-12, will feature several special guests. Dr. George E. Gardner, executive director, Judge Baker Guidance Center for Childhood and Youth of Boston, will give the keynote address and lead several discussion groups. Dr. Lloyd Cook, Wayne University, Detroit, and Dr. Lucille Allen, Cornell University, Ithaca, N. Y., will participate in the sections on education. Dr. George Stevenson, National Committee for Mental Hygiene, will act as consultant for several sections, and Dr. Jack Ewalt, director of the Galveston Psychopathic Hospital and president of the Texas Society for Mental Hygiene, will discuss psychosomatic medicine at a general meeting on the evening of April 10.

AMERICAN COLLEGE OF CHEST PHYSICIANS

The thirteenth annual meeting of the American College of Chest Physicians will be held at Atlantic City, N. J., June 5-8. An interesting scientific program, including prominent speakers from other countries, has been planned. Examinations for Fellowship will be held June 5. Applicants who plan to take these examinations should communicate at once with the Executive Secretary, American College of Chest Physicians, 500 North Dearborn Street, Chicago 10.

OBSTETRICS AND PEDIATRICS COURSES OFFERED AT GALVESTON

The University of Texas School of Medicine has announced programs and speakers for two postgraduate refresher courses in Galveston, one in obstetrics for March 17-22, and one in pediatrics for March 31-April 5.

The course in obstetrics, being given by the Department of Obstetrics and Gynecology of the University in collaboration with the Children's Bureau of the U. S. Department of Labor, will offer the following guest speakers:

DR. NOEL R. BAILEY, Fort Worth.
DR. L. A. CALKINS, Kansas City, Kans.
DR. A. F. CAIRE, New Orleans.
DR. WALTER T. DANNREUTHER, New York.
DR. H. L. GARDNER, Houston.
DR. HERMANN A. JOHNSON, Houston.
DR. ROBERT A. JOHNSTON, Houston.
DR. S. FOSTER MOORE, San Antonio.
DR. WALTER S. MORSE, Houston.
DR. D. M. PATON, Houston.
DR. FRANK A. WHITACRE, Memphis, Tenn.

In addition, the following members of the University staff will participate: Drs. Hiram P. Arnold, Virgil C. Baxter, Willard R. Cooke, John J. Delany, James T. Downs, J. L. Jinkins, Jule K. Lamar, Charles H. Nash, H. R. Robinson, David L. Traylor, W. B. Reading, and E. E. Wilkinson.

Round-table discussions, as well as lectures, will be held each day. On March 17, prenatal care, pelvimetry, analgesia, episiotomy, forceps, cesarean section, and multiple births will be considered; March 18, dystocia, contraction ring, tetanic contraction, prolapse cord, puerperal infection, and clinical-pathological conference; March 19, sterility, placenta abruptio, placenta previa, rupture and inversion of the uterus, postpartum hemorrhage, and postpartum examination; March 20, abortion, prolapse, cystocele, rectocele, hyperemesis, hypertension, nephritis, and eclampsia; March 21, ectopic pregnancy, premature labor, premature infant, intracranial hemorrhage, Rh factor, damaged and cancerous cervix; and March 22, postpartum retroversion, fibromyoma uteri and ovarian cysts, endometriosis, and abdominal operations and operative sequelae in relation to obstetrics.

The spring pediatric conference is again a cooperative undertaking by the University's Child Health Program and the Division of Maternal and Child Health of the State Board of Health. Tuition will be $25, but physicians who wish to do so may apply for special allowances to cover their tuition and expenses.

Guest speakers for the session include the following:

DR. JOHN M. ADAMS, Associate Professor of Pediatrics, University of Minnesota, Minneapolis.

DR. H. H. BOYLE, Associate Professor of Pediatrics, Northwestern University Medical School, and Associate Attending Pediatrician, Children's Memorial Hospital, Chicago.

DR. HUGH MCCULLOCH, Associate Professor of Clinical Pediatrics, Washington University School of Medicine, St. Louis.

DR. WILLIAM A. REILLY, Assistant Clinical Professor of Pediatrics, University of California School of Medicine, San Francisco.

DR. PHILIP STIMSON, Director of Polio Division, Knickerbocker Hospital, and Associate Clinical Professor of Pediatrics, Cornell University School of Medicine, New York.

Following registration on the Fourth Floor of the Clinic Building (Randall Hall) the morning of March 31, the problem of intestinal parasites will be considered. Other subjects include specialty problems in children, afternoon of March 31; diseases of the respiratory tract in children, April 1; problems requiring convalescent care, April 2; well baby care, April 3; renal diseases in children, morning of April 4; clinical and special presentations, afternoon of April 4; and a closing session on diphtheria, urinary infections, and hypothyroidism, morning of April 5.

Registration will be limited to sixty physicians. Applications should be sent to Dr. Arild E. Hanson, Director, University of Texas Child Health Program, Galveston.

SOUTHWEST ALLERGY FORUM

The Southwest Allergy Forum will meet March 31 and April 1 at the Washington-Youree Hotel, Shreveport, La., for the following scientific program:

March 31

Some Faults in the Allergist's Routine—Dr. George L. Waldbott, Detroit, Mich.
Pathology of Allergy, a Bridge to Understanding Clinical Allergy —Dr. Bernard Steinberg, Toledo, Ohio.
Evaluation of Aerosol in the Treatment of Asthmatic Bronchitis—Dr. Boen Swinney, San Antonio.
Nutritional Problems in Allergy (round-table discussion)—Dr. Robert Stone, Birmingham, Ala., leader; Dr. Herbert Rinkel, Kansas City, coordinator.
Dermatological Allergy (round-table discussion) — Dr. Dudley Youman, Shreveport, chairman.
Rationalization in Allergy—Dr. J. Harvey Black, Dallas.
Vitamin Deficiencies: Emphasis on Recent Developments—Dr. Robert Stone, Nutrition Clinic, Hillman Hospital, Birmingham, Ala.
The Symphony of the Seasons—Dr. Herbert J. Rinkel, Kansas City.

April 1

Aerobiology: Evaluation of Airborne Allergens—C. C. Durham, Chicago.
Treatment of Hay Fever (round-table discussion)—Dr. Bernard G. Efron, New Orleans, La., chairman.
Evaluation of New Drugs in Allergy (open forum)—Dr. Joe S Shavin, Shreveport, leader.
Allergy in Relation to Cardiovascular Problems—Dr. Tinsley R Harrison, Dallas.
The Classification of Asthma — Dr. Francis M. Rackemann, Boston.
Allergic Problems in Children—Dr. Jerome Glaser, Rochester, N. Y.

Physicians attending the meeting are invited to a cocktail party at the home of Dr. H. Whitney Boggs at 8 p. m., March 30. Luncheons are planned for each of the two days of the meeting, and a banquet will be held the evening of March 31.

TEXAS SOCIETY OF PATHOLOGISTS

The annual meeting of the Texas Society of Pathologists was held January 26 at Houston. The morning was devoted to a business session at which the following officers were elected: Drs. D. A. Todd, San Antonio, president; W. W. Coulter, Houston, president-elect; John F. Pilcher, Corpus Christi, vice-president; and C. T. Ashworth, Dallas, secretary-treasurer. The next meeting will be held January 25, 1948, in Galveston, although the group will meet to transact business during the annual session of the State Medical Association in May, 1947.

The afternoon of the Houston meeting was devoted to a seminar on microscopic pathology conducted by Dr. S. A. Wallace, Houston, at the Baylor University College of Medicine.

INDUSTRIAL HEALTH MEETING

Professional personnel in industrial health work will meet at the Hotel Statler, Buffalo, N. Y., April 26 through May 4, when the American Association of Industrial Physicians and Surgeons, American Conference of Governmental Industrial Hygienists, American Industrial Hygiene Association, American Association of Industrial Nurses, and American Association of Industrial Dentists convene. The sessions will include discussions for chemists, engineers, nurses, and physicians; and scientific and technical exhibits will be on display.

Further details may be secured from Dr. Edward C. Holmblad, Managing Director of the American

Association of Industrial Physicians and Surgeons, 28 East Jackson Boulevard, Chicago 4.

NATIONAL NEGRO HEALTH WEEK

"Community-wide cooperation for better health and sanitation" will be the special objective of the thirty-third annual observance of National Negro Health Week, to be celebrated March 30 to April 6. National Negro Health Week was founded in 1915 by Booker T. Washington to stress the health needs of his race and to encourage the Negro to take advantage of existing health facilities in his community. As statistics reveal that the Negro still suffers proportionately more ill health and premature death than does his white neighbor, the U. S. Public Health Service has incorporated the movement into its year-round program and encourages communitywide participation in its observance.

U.N.R.R.A. HEALTH DIVISION CLOSES

The United Nations Relief and Rehabilitation Health Division, the largest international health organization the world has yet known, will complete its activities on March 31 after more than three years of work. During this time, U.N.R.R.A. has made available to the health departments of thirteen liberated countries the advice and assistance of its international health staff, and has given medical and sanitation services to more than a million persons in camps for displaced persons. It was necessary to recruit from thirty-five countries a staff totaling nearly 1,200 professional persons, U.N.R.R.A. reports. Dr. Wilbur A. Sawyer, director of the Health Division, believes that the health work has exceeded all expectations, and points to the fact that Europe has gone through the first year and a half after the most widespread and devastating war in history with no major epidemics.

RED CROSS BLOOD BANK SERVICE

The Red Cross plans to offer a peacetime blood bank service to be set up in communities only upon request and in cooperation with established medical and health agencies, according to *The Journal of the American Medical Association.* One of the requirements in making use of such a service, for which blood will be supplied by voluntary donors, is that hospitals and physicians must make no charge to patients for such blood.

LIBRARY NOTES

PACKAGE SERVICE

The package library consists of collections of reprints and other periodical material on various subjects, prepared for lending to members of the Association. Requests for packages should be addressed "Library, State Medical Association of Texas, 1404 W. El Paso Street, Fort Worth 3, Texas." Twenty-five cents in stamps should be enclosed with the request to cover postage and part of the expense of collecting the material. Only one package may be borrowed at a time, and packages are allowed to remain in the hands of the borrower for 14 days.

Packages were mailed from the Library of the State Medical Association to the following during February:

Dr. Charles S. Livingston, Legion—*Actinomycosis* (15 articles).

Dr. D. H. Loving, Amarillo—(3 journals).

Dr. James W. Williams, Mineola—(9 journals).

Dr. Frank H. Kidd, Dallas—*Penicillin* (14 articles); *Streptomycin* (9 articles); *Wounds, healing* (23 articles).

Dr. E. Rischar, Cameron—*Stomach, foreign bodies* (15 articles); *Rectum, prolapse* (9 articles).

Dr. Victor R. Moore, Dalhart—*Hospitals* (16 articles).

Dr. U. S. Marshall, Roswell, N. Mex.—*Eclampsia* (17 articles); *Rheumatic Fever* (12 articles).

Dr. W. Calvin Jones, Pampa—*Uterus, cervix* (14 articles).

Dr. Clarence S. Mast, Lubbock—*Hydatiform Mole and Chorionepithelioma* (13 articles).

Dr. R. B. Grammer, Fort Worth—*Arthritis, therapy* (11 articles); *Heart Diseases, trauma in* (8 articles).

Dr. E. King Gill, Corpus Christi—*Rhinitis, vasomotor* (18 articles); *Sinuses, Nasal, diseases* (11 articles).

Dr. Jack C. Cooper, Dallas—*Mental Diseases, therapy* (22 articles).

Dr. Emerson M. Blake, Lubbock—*Tracheotomy* (10 articles).

Dr. Thomas E. Cook, Dallas—*Filariasis* (13 articles).

Dr. William H. Gordon, Lubbock—*Syphilis, diagnosis* (22 articles).

Dr. M. S. Ragland, Gilmer—(1 journal).

Dr. Vance Terrell, Stephenville—*Medicine, socialized* (7 articles); *Medicine, progress* (18 articles).

Dr. William R. Klingensmith, Amarillo—(1 journal).

Dr. Fred Harrell, Olney—(1 journal).

Dr. T. P. Churchill, Amarillo—*Bones, tumors* (7 articles).

Dr. R. S. Knapp, Corpus Christi—*Alopecia* (8 articles).

Dr. Erle D. Sellers, Abilene—*Pneumonia* (13 articles).

Dr. Ross Owens, San Antonio—*Pneumonia* (26 articles).

Dr. Joe T. Gilbert, Austin—*Thoracoplasty* (15 articles).

Dr. Edward Zidd, Austin—*Blood Pressure, High, surgical therapy* (7 articles).

Dr. H. A. Scott, Austin—*Breast, cancer* (9 articles).

Dr. E. W. Wright, Bowie—*Cancer* (9 articles).

Dr. J. P. Lovett, Olney—*Heparin* (8 articles).

Dr. H. E. Karbach, New Braunfels—*Hospitals, construction* (1 article).

Dr. George Y. Swickard, Orange—*Peptic Ulcer, surgical therapy* (6 articles).

Dr. Oliver W. Suehs, Austin—*Larynx, cancer* (9 articles).

Dr. O. E. Rhode, Colorado City—*Skin, transplantation* (11 articles).

Dr. Charles Mims, Mission—*Psychosomatic Medicine* (16 articles).

Dr. Frank B. Duncan, Amarillo—(2 journals).

Dr. H. L. Wilder, Pampa—(1 journal).

Dr. Albert C. King, Durham, N. C.—*Lungs, cancer* (24 articles).

Providence Hospital Library, Waco—(2 journals); *Osteochondritis, deformans juvenilis* (12 articles); *Carotid Sinus* (2 articles).

Dr. F. W. B. Rockett, Flatonia—*Deficiency Diseases* (6 articles).

Dr. Albert A. Tisdale, Austin—*Tuberculosis, therapy* (4 articles).

Dr. J. B. Rountree, Jr., Lubbock—*Nephritis, in infants and children* (17 articles).

Dr. Thelma Patten-Law, Houston—*Labor, complications* (20 articles).

Dr. Pauline Miller, Lubbock—*Meningitis, pneumococcic* (21 articles).

Scott & White Clinic Library, Temple—(1 journal).

Dr. Jack F. Perkins, Dallas—*Hospitals* (7 articles).

Dr. Jack A. Crow, Abilene—*Kidneys, surgery* (8 articles).

Dr. Richard M. Smith, Dallas—*Health* (7 articles).

LIBRARY OF THE
COLLEGE OF PHYSICIANS

Dr. Lyle Robertson, Wichita Falls—*Diet* (21 articles).
Dr. C. G. Allen, Commerce—(1 journal).
Dr. J. T. Boyd, Jacksonville—*Intestines, diverticula* (5 articles).
Dr. C. A. Slaughter, Sanatorium—*Surgery, risks* (7 articles).
Miss Joyce Livingston, Stephenville—*Vital Statistics* (9 articles); *Medicine, progress* (15 articles).
Dr. Virgil C. Baxter, Galveston—Episiotomy (6 articles).
Dr. Ben F. Harrison, Dallas—(2 journals).
Dr. John M. Chapman, Ennis—*Immunity* (25 articles).
Dr. E. O. Nichols, Plainview—*Poliomyelitis* (17 articles).
Dr. Frank C. Hodges, Abilene—*Femur, fractures* (17 articles).
Dr. T. J. Archer, Austin—*Intestines, diseases* (12 articles).
Mrs. J. E. Hogan, Big Spring—*Mental Hygiene* (10 articles).
Dr. John S. Bagwell, Dallas—*Thrombosis and embolism* (13 articles).
Dr. W. C. Hixson, San Angelo—*Periarteritis, nodosa* (19 articles).
Dr. Seth Downs, Kilgore—*Streptomyein* (8 articles).
Dr. M. E. Jacobson, Amarillo—*Hematuria* (6 articles); *Urethra, abnormalities* (11 articles).
Dr. L. R. Byrd, Port Arthur—*Foot, fractures* (21 articles).

Packages on compulsory sickness insurance to superintendents, debate coaches, and students in Texas High Schools, 5.

ACCESSIONS

Chicago, Year Book Publishers—Hodges, Lampe and Holt: Radiology for Medical Students.
Springfield, Illinois, Charles C. Thomas, Publisher—Moore: Penicillin in Syphilis.

SUMMARY

REPRINTS RECEIVED, 1,030. LOCAL USERS, 80.
JOURNALS RECEIVED, 221. BORROWERS BY MAIL, 69.
ITEMS CONSULTED, 408. PACKAGES MAILED, 79.
ITEMS TAKEN OUT, 473. ITEMS MAILED, 826.
TOTAL ITEMS CONSULTED AND MAILED, 1,707.

MOTION PICTURE FILM LIBRARY

Motion picture films on medical subjects, 16 mm., both silent and sound, some in color, and suitable for either medical or lay audiences, are available for loan to county medical societies, hospital staffs, or individual physicians, on request. Borrowers will be required to pay only the cost of shipment of the films, by express, with insurance, and for any damage to films while in the hands of the borrower.

Requests for films should be addressed to "Motion Picture Film Library, State Medical Association of Texas, 1404 West El Paso Street, Fort Worth 3, Texas." A list of available films, with descriptions, will be furnished on request.

The following motion picture films were loaned by the Film Library of the State Medical Association of Texas during February:

Analgesia, Continuous Caudal (Available through the courtesy of Becton, Dickinson & Company)—Tarrant County Medical Society, Fort Worth.

Anesthesia, Intravenous (Available through the courtesy of Abbott Laboratories)—Blackwood Clinic & Hospital Staff, Comanche; Mercy Hospital Staff, Slaton; and Gray-Wheeler Counties Medical Society, Pampa.

Appraisal of the Newborn (Available through the courtesy of Mead Johnson and Company)—International Post Graduate Medical Assembly of South Texas, San Antonio.

Below Knee Amputations (Available through the courtesy of the Medical Department of the U. S. Army)—Victoria Hospital Staff, Victoria.

Chest Diseases, Surgery in (Available through the courtesy of the British Information Services)—Medical & Surgical Clinic, Fort Worth.

Choose to Live (Available through the courtesy of the U. S. Public Health Service and the American Society for the Control of Cancer)—Hallettsville Reading Club, Hallettsville.

D. D. T., the Story of (Available through the courtesy of the British Information Services)—Medical & Surgical Clinic, Fort Worth.

Empyema, the Treatment of (Available through the courtesy of Mead Johnson and Company)—Medical & Surgical Clinic, Fort Worth.

Eyes for Tomorrow (Available through the courtesy of the Hurst Eye, Ear, Nose & Throat Clinic, Longview)—Lamar College, Beaumont; Kiwanis Club, Brownwood; and Phi Eta Sorority, San Antonio.

Eyes, Your Children's (Available through the courtesy of British Information Services)—Vernon Public Schools, Vernon, and Kiwanis Club, Brownwood.

From Moo to You (Available through the courtesy of the Borden Company)—Vernon Public Schools, Vernon.

Goiter Surgery (Available through the courtesy of Mead Johnson & Company)—Medical & Surgical Clinic, Fort Worth.

Goodbye, Mr. Germ (Available through the courtesy of the Texas Tuberculosis Association)—Vernon Public Schools, Vernon.

Health is a Victory (Available through the courtesy of the American Social Hygiene Association)—Public Health Department, Fort Worth.

Hysterectomy (Available through the courtesy of Mead Johnson & Company)—Medical & Surgical Clinic, Fort Worth.

In Defense of a Nation (Available through the courtesy of the American Social Hygiene Association)—Public Health Department, Fort Worth.

Infantile Paralysis, Orthopedic Treatment of (Available through the courtesy of Mead Johnson & Company)—Victoria Hospital Staff, Victoria.

Know for Sure (Available through the courtesy of the Texas State Board of Health)—Public Health Department, Fort Worth.

Lease on Life (Available through the courtesy of U. S. Public Health Service)—Public Health Department, Fort Worth and Kiwanis Club, Brownwood.

Magic Bullets (Available through the courtesy of the U. S. Public Health Service)—Public Health Department, Fort Worth.

Modest Miracle (Available through the courtesy of Standards Brands, Inc.)—Allied Science Club, Tyler High School, Tyler.

Normal Delivery (Available through the courtesy of Mead Johnson and Company)—Phi Eta Sorority, San Antonio, and Ragland Clinic-Hospital, Gilmer.

Plain Facts (Available through the courtesy of the American Social Hygiene Association)—Public Health Department, Fort Worth.

Premature Infant, the Care of (Available through the courtesy of Mead Johnson and Company)—Ragland Clinic-Hospital Staff, Gilmer.

Poliomyelitis, Sister Kenny Method of Treatment (Available through the courtesy of Dr. Herbert Hipps, Waco)—Victoria Hospital, Victoria, and Renger Clinic, Hallettsville.

Resuscitation of the Newborn (Available through the courtesy of Mead Johnson and Company)—Ragland Clinic-Hospital, Gilmer.

Sulfonamide Therapy (Available through the courtesy of the Lederle Laboratories, Inc.)—Phi Eta Sorority, San Antonio.

Urinary Antisepsis (Available through the cour-

tesy of Mead Johnson and Company)—The Doctor's Journal Club, Waco.

LIBRARY NEEDS

The journals listed are needed by the Library of the State Medical Association to complete volumes for binding. Any of these numbers will be acceptable either as a gift or for purchase. It is preferable that the Library, 1404 West El Paso Street, Fort Worth 3, be notified regarding items available, and the prices of such items, if any, before shipment is made.

Journals needed by the Library of the State Medical Association are as follows:

Archives of Internal Medicine, Vol. 66, No. 4 (Oct.) 1940.

Archives of Otolaryngology, Vol. 33, Nos. 1-2 (Jan.-Feb.) 1941.

Industrial Medicine, Vol. 3, Nos. 7-12, inclusive (July-Dec.) 1934.

Journal of Pediatrics, Vol. 18, No. 3 (Mar.) 1941.

Journal of Pediatrics, Vol. 19, Nos. 2-3 (Aug.-Sept.) 1941.

Surgery, Gynecology & Obstetrics, Vol. 76, No. 6 (June) 1943.

NEW MOTION PICTURES FOR THE FILM LIBRARY

The Motion Picture Film Library of the State Medical Association has received the following films which are available for loan upon request:

Safer Gastrectomy. 16 mm., sound, color, running time, 16 minutes. (Available through the courtesy of Billy Burke Productions, Hollywood, Calif.)—This is a very outstanding teaching film portraying the salient steps of gastric resection surgery. It shows the use of the new Alesen T-tube, which aids in the prevention of postoperative duodenal stump disruption. Through the medium of x-rays, the disintegration of the tube during the first eight days postoperatively is shown.

Human Fertility. 16 mm., sound, color, running time, 50 minutes. (Available through the courtesy of Ortho Products, Inc., Linden, N. J.)—This picture gives the physician a concise, up-to-date presentation of contraceptive methods in order that he may prescribe effectively for the requirements of individual patients.

Varicose Veins and Their Complications. 16 mm., sound, color, running time, 30 minutes. (Available through the courtesy of Becton, Dickinson & Co., Rutherford, N. J.)—This film, by means of animated charts and moving pictures of actual clinical procedures, aims to clarify present knowledge of the anatomy, physiology, and pathology of varicose veins and their complications. It shows a safe, simple, economical, and effective method of treatment.

Hypodermic Syringes and Needles: Their Care and Function. 16 mm., silent, color, running time, 62 minutes. (Available through the courtesy of Becton, Dickinson & Co., Rutherford, N. J.)—This picture sets up basic standards for syringes and needles, shows standard accepted techniques for their care, and syringes and needles in use, with simple injection techniques.

Prevention and Immediate Care of Athletic Types of Injuries. 16 mm., silent, color, running time, 45 minutes. (Available through the courtesy of Becton, Dickinson & Co., Rutherford, N. J.)—This is a teaching picture which is intended to give a more complete understanding of the problems of athletic types of injuries. It shows the most efficient methods of taping with adhesive tape, elastic adhesive bandages, and with Ace all-cotton and Ace Lastex Bandages. Starting with the ankle, it shows preventive measures, also methods for immediate care of athletic injuries such as various knee bandaging techniques, tendon and muscle injuries, groin and hip bone injuries, rib and shoulder, elbow, wrist, and fingers.

Oxygen Therapy in Heart Disease. 16 mm., sound, color, running time, 30 minutes. (Available through the courtesy of the Linde Air Products Co., New York.)

BOOK REVIEWS

[1]**The Chest, A Handbook of Roentgen Diagnosis.** By Leo G. Rigler, Professor and Chief, Department of Radiology, University of Minnesota. Cloth, 352 pages. Price, $6.50. Chicago, The Year Book Publishers, Inc., 1946.

Rigler has added another atlas to the handbook series. The introductory chapter is devoted to a description of the normal chest and accepted methods of examination. Following this chapter, a brief outline of the pathologic conditions that are to be illustrated in the book is presented.

Subsequent pages are profusely illustrated, demonstrating the common chest abnormalities, including those of the chest wall.

The author presents a clear description of every pathologic entity prior to presenting a logical interpretation of the roentgen films depicting the disease.

That this book will enhance the Atlas Series is not doubted. It provides the busy practitioner and the specialist with a ready reference book containing clear roentgen positives, plainly identified. For the physician who desires simple, factual, nontheoretical interpretations, this book is recommended.

[2]**An Introduction to Essential Hypertension.** By Richard F. Herndon, M. D., F. A. C. P. Cloth, 88 pages. Price, $2.50. Springfield, Illinois, Charles C. Thomas, Publisher, 1946.

This little book is intended by the author to furnish the busy physician an outline of the present opinions on a subject which is still very unsettled. Straightforward definitions as well as short discussions of basic physiology, clinical aspects, diagnosis, and treatment comprise the contents of the presentation. The section on treatment is very hopeful that investigations, which are now in progress, may supply significant help in the field of organotherapy. It also cites the several views regarding the value of surgical treatment in hypertension from which it would seem that, on the whole, the results have not been brilliant. A valuable "stimulator" for all interested in this timely subject is found in this small volume.

[3]**Electrocardiography in Practice.** By Ashton Graybiel, M. D., Captain, Medical Corps, U. S. Naval Reserve, Coördinator of Research, U. S. Naval School of Aviation, Pensacola, Florida, and Paul D. White, M. D., Lecturer in Medicine, Harvard Medical School, and Physician, Massachusetts General Hospital; with the assistance of Louise Wheeler, A. M., Executive Secretary, the Cardiac Laboratory, Massachusetts General Hospital, and Conger Williams, M. D., Assistant in Medicine, Harvard Medical School and Massachusetts General Hospital. Cloth, 458 pages. Second edition, with 323 illustrations. Price, $7.00. Philadelphia and London, W. B. Saunders, 1946.

This, the second edition of this work, evidences thorough revision and many improvements. Recent advances in the science of clinical electrocardiography are manifest throughout, including the newly added section of precardial leads. Included among

[1]Reviewed by Ben DuBilier, M. D., Austin, Texas.
[2]Reviewed by F. W. Halpin, M. D. Fort Worth, Texas.
[3]Reviewed by Victor E. Schulze, M. D., F. A. C. P., San Angelo, Texas.

the new illustrations are many with chest leads, CF_2, CF_4, and CF_5, which the authors now employ always with the standard, and chest leads in complementary and supplementary relationships. Likewise improved are the legends accompanying the illustrations; the more complete case analyses allow for better integration of electrocardiographic data with clinical findings. The section on recent myocardial infarcts, too, has been enlarged and is outstanding.

The volume is made up of five parts: The first deals with physiologic principles and technique, and includes a section on precardial leads. The second is concerned with the broad range of variations of the normal, a consideration which is proper, and is adequately treated. The third is devoted to the arrhythmias with emphasis given to appraisal of the clinical significance. This section might be improved further by giving discussion in some instances to alternative considerations in interpretations, that is, figure 53, in which the abnormality of the ventricular complex is attributed to bundle branch block, whereas origin of the idioventricular rhythm below the bifurcation of the auriculoventricular bundle deserves consideration. The fourth includes electrocardiographic patterns encountered in the various diseases of the heart, and a section on artefacts. The fifth part is comprised of a new series of electrocardiograms for practice in interpretation. Two appendices are devoted to the subjects of unipolar and esophageal leads, and effects of exercise and low oxygen tension tests.

The purpose of the authors, "to aid in the interpretation of electrocardiograms," is admirably attained. The internist will find in this second edition, mature evaluation of recent advances readily applicable. The excellent integration of abundant clinical data with electrocardiographic findings will enable the general physician to learn better to evaluate electrocardiography in terms of clinical cardiology.

The Human Frontier. A New Pathway for Science toward a Better Understanding of Ourselves. By Roger J. Williams. Cloth, 314 pages. Price, $3.00. New York, Harcourt, Brace and Company, Inc., 1946.

A challenge to anyone who reads this book is offered by the author, who is director of the Biochemical Institute of the University of Texas and a biochemist whose research on vitamins is internationally known. Dr. Williams bases his thesis on the fact that most research, both in the natural sciences and in the social sciences, has treated man in the abstract, average persons rather than individuals. He points out that failure to understand and appreciate physiological and psychological differences leads to many of the petty irritations which cause friction in human relationships.

The first half of the book enumerates some of the differences in metabolism, the senses, endocrine glands, and other physical attributes. While such differences are known to exist, the exact way in which individuals differ and the significance which these differences have for behavior, achievement, and social interaction are not known. Dr. Williams urges that an effort be made through the coöperation of specialists in many fields to study individual human beings so thoroughly that they, as units which make up society, will be as completely understood as the chemical elements which are compounded into modern plastics. The latter portion of the book discusses some of the fields in which knowledge from this study of "humanics" might be applied: education, marriage, criminology, medicine, leadership, employment, international relations.

Perhaps the chapter with the greatest appeal for physician readers is the one devoted to medicine and medical research. Dr. Williams points to the fact that research by trained medical specialists has often lagged and cites specific examples as evidence. The medical profession is encouraged to support clinical research whenever and wherever possible.

NEWS

Contributions to this department will be appreciated. News should be of general medical interest, such as public health activities, new hospitals, personal items of more than local value, etc. News for a particular number of the JOURNAL should be in the hands of the Editor not later than the fifteenth of the preceding month.

The Dallas Academy of Ophthalmology and Otolaryngology entertained Dr. Daniel B. Kirby, New York, on February 4. Following a luncheon, Dr. Kirby spoke on "Cataract Surgery with Particular Reference to Escape of Vitreous." His main address, on "The Cause and Treatment of Uveitis," was delivered at a dinner in his honor that evening. Both meetings were at the Dallas Athletic Club.

The National Physicians Committee met in Dallas on February 28, reports the Dallas *Times-Herald.* Opportunity for the meeting was provided by a celebration of the seventy-fifth birthday of Dr. E. H. Cary, Dallas physician who is chairman of the committee. Drs. William F. Braasch, Rochester, Minn.; George H. Coleman, Chicago; and Edward H. Skinner, Kansas City, members of the executive committee, and John M. Pratt, Chicago, administrator of the committee, were in Dallas for the dinner honoring Dr. Cary and for the N. P. C. session.

The Dallas Health Museum presented Mrs. Ella May Keith O'Brien, Dallas reviewer, in a discussion of the world's first ovariotomy on January 19 in connection with a current showing of a series of original paintings by Dean Cornwell depicting the progress of American medicine, states the Lancaster *Herald.* The collection of paintings, owned by a pharmaceutical concern, was on display in the museum throughout January.

The University of Houston has inaugurated a comprehensive student health program following approval by the board of regents of the broadened program and of a $1.50 fee per semester to finance it, according to the Houston *Chronicle.* Dr. Allan Collette, physician for the school's athletic teams, will be the official physician and will be assisted by a full-time day nurse, two evening nurses to remain on duty until classes are over each day, and a laboratory technician. Medical attention in accident and illness cases, routine examinations as requested, thorough examinations for all physical education students, and follow-up examinations for all who have physical defects will be provided in the program, which is open to faculty members as well as students.

A Hermann Hospital Loan Fund for student nurses was recently started by a $100 contribution given by a young physician at the hospital because of a young woman whose training as a nurse has been interrupted by the development of cancer, first of the ankle and more recently of the lungs, the Houston *Chronicle* informs. The young nurse refused to allow her illness to halt her studies until she was confined to her bed. The physician dedicated his gift to the "splendid courage" of the student nurse, who has been denied fulfillment of her career. The fund has grown to $160, and fellow nurses are planning various social programs which they hope will add to it. The scholarship will be given to a student nurse who best exemplifies proper care and consideration of patients.

The San Antonio Medical Foundation applied in January for an incorporating charter, reports the

San Antonio *Express*. The foundation is the result of long months of planning by the Chamber of Commerce. Seven trustees have already been appointed by the executive committee of the Chamber of Commerce as authorized by its board of directors. Those named include John M. Bennett, Jr., vice-president, Standard Trust Co.; Melrose Holmgreen, vice-president, Alamo Iron Works; A. J. Lewis, attorney; Thomas B. Slick, owner of Essar Ranch; Albert Steves III, president of Steves Sash and Door Co.; Mrs. Edgar Tobin; and Col. W. B. Tuttle, chairman, Public Service Board. The board has authority to elect additional directors. It is planned to employ an outstanding medical authority to make a detailed survey of the health needs of San Antonio. The foundation is exclusively for benevolent, charitable, and educational purposes, and will be concerned with promotion of facilities for medical, dental, and nursing education, hospitalization and treatment of the sick, and medical and dental research. It will promote and assist other medical schools in training programs, will award scholarships, and will accept and administer gifts and donations for use in carrying out the aims of the organization.

A Blood Bank for Wichita Falls is being considered by the Wichita County Medical Society, the staffs of three hospitals of the city, and the Red Cross, reports the Wichita Falls *Record-News*. If the proposed project is carried through, the Red Cross will probably provide the physical facilities for acquiring blood and the nontechnical personnel necessary to solicit and accept blood donations. Actual handling of the blood will be in charge of a pathologist already jointly serving the three hospitals. Live blood donated by citizens of Wichita County will be made available without cost, the only cost to the patient being the small handling charge made by the hospital.

A Crippled Children Clinic was held in Plainview on February 8 with Drs. Sim Driver and Eugene P. Legg of Dallas making the examinations, informs the Floydada *Hesperian*. Children suffering from poliomyelitis or other conditions of an orthopedic nature were invited to attend the clinic.

A Psychiatry Clinic under the sponsorship of the McLennan County Mental Hygiene Society has been opened in Waco, states the Waco *Times-Herald*. The clinic, which will be open two evenings each week, will provide free advice and in some instances free treatment. Its main purpose is to provide a service to which social agencies may refer clients when it appears personality adjustment or adjustment of home or environmental surroundings is necessary. However, any person who desires may arrange for an interview at the clinic. Usually, those who are financially able to pay for treatment, if it is found necessary, will be referred to a private physician. Dr. Charles L. Yeager, member of the Veterans Hospital staff, will direct the clinic. Two Waco psychiatrists, Drs. John E. Talley and Carl Friedman, will give their time, as will psychiatrists from the Veterans Hospital. In addition, members of the psychological staff of the hospital and psychology students from Baylor University will assist. Much of the work of the clinic will be carried on by social workers, and clerical work will be done by volunteers.

Hospital and Clinic Facilities Expand.—Scott and White Hospital has purchased 340 acres of land adjacent to the south city limits of Temple as the first step in a $5,000,000 expansion program, according to the Beaumont *Journal*. Plans call for the beginning of construction in 1948 of a ten-story clinic building with a foundation sufficient to carry fifteen stories. Additional units will include a ten-story hospital building, which will have a capacity of 1,000 beds; a building for graduate medical training and research in cancer, circulatory diseases, arthritis, and other scientific subjects; a nurses' home; a dormitory for interns, residents, and research fellows; a power plant to serve all buildings; and a building for animal research. The clinic and hospital buildings will be erected in the form of four crosses joined in the center by a long central building which will house services jointly used by both, such as laboratories, library, and records. The center of each cross will house banks of elevators and service facilities.

Dr. L. O. Anderson is building a new seven-bed hospital and clinic in Pilot Point, reports the Pilot Point *Post-Signal*. The building will be of face clay tile in a soft pastel shade, with a glass brick front for the physician's office. Laboratory, x-ray room, photographic dark room, kitchen, delivery room with one bed, operating room, three two-bed rooms, and living quarters for nurses will be provided in the structure.

The Jones-Watkins Clinic, Wellington, held a formal opening February 1, states the Wellington *Leader*. A building was moved adjacent to the office occupied by Dr. E. W. Jones and Dr. C. B. Jones, and an additional room was added to connect the two buildings. Dr. E. K. Jones, son of Dr. and Mrs. E. W. Jones, and Dr. D. V. Watkins, both of whom were in military service, will be associated with the clinic. Other personnel will include a laboratory technician, business manager, receptionist, and office attendant. Several pieces of major medical equipment have been ordered.

Sunnyside Sanatorium, a private hospital near Kerrville for tuberculosis patients, has been sold by Dr. William R. Fickessen to Mr. and Mrs. L. C. Gatz, according to the Kerrville *Times*. The institution will be open to all qualified physicians and surgeons for the treatment of tuberculosis patients. Dr. Fickessen will give his time to private practice in San Antonio.

A tuberculosis clinic will be erected in Longview this year under plans agreed to by the Gregg County Commissioners Court and the Gregg County Tuberculosis Association, information from the Longview *Daily News* reveals. The Commissioners Court has authorized $20,000 for erection of a building on the county hospital grounds and the Tuberculosis Association will furnish the latest diagnostic equipment from funds raised through the sale of Christmas seals. Nearly $6,500 was received from this source during the past Christmas season. A roentgen diagnosis program for school children and adult workers will be one of the first projects of the clinic, which has the support of the county medical society and other local groups.

The International Medical Congress, held in Monterrey, Mexico, February 7-8, under sponsorship of various organizations including the State Medical Association of Texas, attracted 104 physicians, of whom more than half were from Texas, the Dallas *News* informs. Dr. McIver Furman, Corpus Christi, was elected president; Dr. Francisco Conseco, Laredo, secretary; and Miss Pansy Nichols, Austin, reelected executive secretary. Laredo was chosen as host for the next meeting in February, 1948. The Monterrey session was the second meeting of the congress.

Hospital Staffs.—Shannon Memorial West Texas Hospital, San Angelo, will be headed by Dr. William C. Hixson, son of the late Dr. J. S. Hixson, who had been superintendent of the hospital since its establishment, reports the San Angelo *Standard*. Terms of the will of Mrs. Margaret Shannon, which created a trust fund to establish the hospital, named the elder Dr. Hixson as head of the hospital with authority to name his successor. The younger Dr. Hixson had served as assistant medical director of the hospital since last May and now becomes its superintendent, following the death of his father. The board of trustees of the hospital will name a trustee and

chairman of the board to succeed the elder Dr. Hixson, and will henceforth have the power to name the hospital's superintendent.

The Clinic-Hospital of San Angelo will be served throughout 1947 by Dr. J. V. Sessums, president; Dr. R. E. Windham and Dr. R. M. Finks, vice-presidents; Dr. D. D. Wall, secretary-treasurer; and Dr. W. E. Schulkey, medical director, according to the San Angelo *Standard*.

Providence Hospital, Waco, has announced its new staff for the year as follows: Drs. R. W. Crosthwait, president; E. C. Taylor, vice-president; and Howard Wells, secretary-treasurer, reports the Waco *Tribune-Herald*. The chiefs and assistant chiefs, respectively, of the various services include Drs. Leslie Sadler and R. W. Crosthwait, surgery; D. D. Warren and M. B. Aynesworth, internal medicine and general practice; C. H. Reese, obstetrics; and F. William Hoehn, pediatrics.

St. Mary's Infirmary, Galveston, has elected new officers for its medical staff, states the Galveston *Tribune*. Dr. Emil Klatt is president; Dr. Lamar Roos, vice-president; and Dr. Edgar Jones, Jr., secretary. The executive committee, composed of Drs. George T. Lee, J. L. Jinkins, and Willam Marr, was reelected.

Lamar Hospital, Paris, will be headed by the following staff officers during 1947: Dr. C. M. Townsend, president; Dr. J. L. Joplin, vice-president; and Mrs. Dorothy Briney, hospital superintendent, secretary.

Texas Medical Center.—The Episcopal Diocese of Texas is campaigning for $1,000,000 for St. Luke's Hospital, to be built in the Texas Medical Center, Houston, according to the Houston *Post*. A gift of $1,000,000 from H. R. Cullen for the hospital and an offer by the M. D. Anderson Foundation, which furnished a site for the building, to contribute $1 for each $2 raised by the church above the Cullen gift, will bring total funds for the project to $2,500,000. It is proposed to build a 250 or 300 bed general hospital which will accept a minimum number of pay patients to help support the maximum number of charity patients. Although the Episcopal Diocese of Texas will celebrate its one hundredth anniversary in 1949, St. Luke's Hospital is the first lay project which it has had.

A quorum of State Legislators were in Houston on February 8 as guests of the Texas Medical Center board of trustees, the Houston Chamber of Commerce, Houston Fat Stock Show and Exposition officials, and city and county officials, according to the Houston *Post*. The Legislators arrived in the city early in the morning and were entertained for meals, at the stock show and rodeo, and by a tour of the city. The primary purpose in inviting members of the Legislature to come to Houston was to explain to them at firsthand the plans for the Texas Medical Center and especially the part the University of Texas is expected to play in the project. The board of regents of the University is asking the Legislature to appropriate $2,000,000 to add to $4,250,000 raised by other means so that the M. D. Anderson Hospital for Cancer research, the dental school, the preceptorial training center, and the school of public health—all units of the University—can be put into operation as a part of the center. Dr. E. W. Bertner, president of the board of trustees of the medical center; Dr. Frederick C. Elliott, secretary of the board and president of the University of Texas School of Dentistry; and D. K. Woodward, Jr., Dallas, chairman of the University of Texas board of regents, spoke to the lawmakers.

University of Texas.—Postdoctoral fellowships of $2,400 plus payment of fees and predoctoral fellowships of $900 to $1,200 plus payment of fees are being offered to students in the fields of science relating to cancer, according to an announcement from the Dean of the Graduate School, University of Texas, Austin. The fellowships, provided from funds from the Rosalie B. Hite estate, are open only to promising research workers or graduate students whose previous training and proposed fields of work come within the scope of the cancer problem. Students will be free to work in the Main University or to combine work in the Main University and the Medical Branch or the M. D. Anderson Hospital for Cancer Research.

Several new grants have been announced by the University of Texas Medical Branch. J. B. Roerig and Company, Chicago, has given $2,500 to the Tissue Culture Laboratory, under the direction of Dr. C. M. Pomerat, for research on factors involved in cellular growth and inhibition of growth. The National Foundation for Infantile Paralysis has granted $11,675 for study by Dr. Morris Pollard in developing a practical serologic test for the diagnosis of poliomyelitis. Smith, Kline, and French Laboratories, Philadelphia, have made a two year grant of $6,000 for the support of pharmacological studies of new compounds under the direction of Dr. George Emerson. Meyer Epstein and Jerome Epstein, San Antonio, have donated $5,000 for establishment of the Leib Epstein Medical Student Loan Fund. Wichita Falls alumni of the University have contributed an initial $500 for the establishment of a research fund for the study of deafness. Dr. J. B. Nail, one of the Wichita Falls physicians, has explained that the group expects to maintain the research fund by annual grants.

A postgraduate refresher course in the fundamental medical sciences with clinical correlation was held at the University of Texas School of Medicine, February 24 through March 1, according to the Galveston *Tribune*. The program was designed for practitioners interested in a survey of recent advances in medicine as correlated with the basic sciences. In addition to members of the University staff, the following guests gave lectures: Dr. R. L. Clark, Jr., director of the M. D. Anderson Hospital for Cancer Research, Houston; Dr. J. V. Irons, director of the Division of Laboratories, State Health Department, Austin; Dr. Arthur Grollman, professor of medicine, Southwestern Medical College, Dallas; J. Louis Neff, executive director, Texas Division, American Cancer Society, Houston; Dr. Charles Phillips, Department of Surgical Pathology, Scott and White Clinic, Temple; Dr. C. P. Rhoads, professor of pathology, Cornell Medical College, and director, Memorial Hospital, New York; and Dr. C. A. Stevenson, Department of Radiology, Scott and White Clinic, Temple.

Commencement exercises for approximately 85 medical students and 38 nursing students were held by the University of Texas School of Medicine and John Sealy College of Nursing at the city auditorium, Galveston, on February 14. The Galveston *Tribune* reports that Dr. Jacques Gray, dean of the University of Oklahoma School of Medicine, was the principal speaker. A selected group of musicians from the Houston Symphony, under the direction of Joseph Henckel, provided music at the graduation program and at a reception for students, their friends and families, at the Rebecca Sealy Nurses Home prior to the commencement exercises.

Dr. Stuart Mudd, professor of bacteriology at the University of Pennsylvania, Philadelphia; Dr. Owen H. Wangensteen, professor of Surgery, University of Minnesota, Minneapolis; and Dr. W. E. Gallie, professor of surgery, University of Toronto, have been recent speakers at the University of Texas Medical Branch.

The Medical Dames, an organization of wives of students at the University of Texas School of Medicine, held its annual banquet January 17, with Dr. D. Bailey Calvin, associate dean, as toastmaster,

and Dr. Chauncey D. Leake, vice-president and dean, as the speaker, states the Galveston *Tribune*.

Dr. Eric Ogden, professor of physiology at the University of Texas School of Medicine, has been appointed southwestern representative to the newly organized American Foundation for High Blood Pressure, according to the Galveston *Tribune*. The organization was established recently to support research on high blood pressure and is being sponsored by a group of Cleveland scientists.

Dr. Willard Marmelzat, resident in dermitology and syphilology at the University of Texas School of Medicine, is author of a recently published book on the musical achievements of physicians, entitled "The Musical Sons of Aesculapius," informs the Galveston *News*.

Baylor University College of Medicine.—Dr. Kenneth L. Burdon, professor and chairman of the Department of Bacteriology and Immunology at Baylor University College of Medicine, Houston, was in Washington recently at the special invitation of the Antibiotics Study Section of the National Institute of Health to present a report on eumycin, the antibiotic substance discovered and developed by Dr. Burdon and Dr. Edwin A. Johnson in the Baylor laboratories. A conference on antibiotics research, under the auspices of the U. S. Public Health Service, was held by scientific workers and representatives from commercial manufacturers of antibiotic preparations to discuss penicillin, streptomycin, and five other antibiotics, including eumycin. Prepared from culture of a harmless bacterium common in dust and soil, eumycin prevents the growth of several kinds of disease-producing fungi. Dr. Burdon and Dr. Johnson hope the antibiotic will be effective in the treatment of dermatophytosis and may find its greatest use in combatting tuberculosis.

Dr. Richard Cattell, surgeon with the Lahey Clinic, Boston, and Dr. Robert A. Moore, acting dean of the Washington University School of Medicine, St. Louis, have recently lectured at Baylor University College of Medicine, Houston, under sponsorship of the Phi Chi and Phi Beta Pi medical fraternities, respectively, report the Houston *Press* and *Post*.

Southwestern Medical Foundation. — Dr. E. H. Cary, founder of the Southwestern Medical Foundation, Dallas, has been reelected to its presidency, according to the Dallas *News*. Karl Hoblitzelle, vice-president; Fred Lange, managing director; H. B. Sanders, general counsel; and Herbert Marcus, treasurer, were also reelected.

The Advisory Council to Southwestern Medical Foundation, at present composed of 204 members, is headed by Randle R. Gilbert, president of the Federal Reserve Bank, Dallas, reports the Irving *Record*. Mr. Gilbert was named chairman at a recent meeting of the trustees of the foundation. It is planned to increase the membership of the council so that each county in each of the southwestern states will be represented. Members function in an advisory capacity to aid Southwestern Medical College in better serving the Southwest.

Personals

Dr. Tinsley R. Harrison, professor of internal medicine, Southwestern Medical College, Dallas; *Dr. James A. Greene*, professor of medicine, Baylor University College of Medicine, Houston; and *Dr. N. D. Buie*, Marlin, president of the Federation of State Medical Boards of the United States, participated in the program of the Forty-Third Annual Congress on Medical Education and Licensure, February 9-11, in Chicago.

Dr. Margaret Watkins, Dallas, has recently been awarded a diploma in the American Academy of Orthopedic Surgeons, thus becoming the third woman member of the approximately 900 member organization, reports the Dallas *News*. Her partner, *Dr. Ruth Jackson*, is one of the other two women members.

Dr. Virginia H. Boyd, Abilene, returned early in February after attending the sixteenth annual midwinter postgraduate clinical convention in ophthalmology and otolaryngology at Los Angeles, according to the Abilene *Reporter-News*.

Dr. C. W. Gray, Comanche, has recently been reappointed county health officer, informs the Comanche *Chief*.

Dr. M. L. Fuller on February 1 resigned his position as director of the Milam County Health Unit to become director of the Brown County Health Unit, the Cameron *Enterprise* states. He was succeeded in the Milam County directorship by *Dr. E. S. Freeman*, formerly of Jasper.

Dr. Roy E. Pitre, Beaumont, has been appointed health officer for the south half of Jefferson County, according to the Beaumont *Journal*.

Dr. Charles F. Mares, Galveston, has been reappointed county health officer, informs the Galveston *Tribune*.

Dr. F. E. Sadler, formerly director of the Corsicana Health Unit and more recently superintendent of the State Veterans Hospital at Sulphur, Okla., has assumed the duties of director of the Midland-Ector-Howard County Health Unit with headquarters at Midland, states the Midland *Reporter-Telegram*. He replaces *Dr. Fred R. Turner*, who is now director of the Cameron County Health Unit in San Benito.

Dr. John Travis, Jacksonville, has been named Cherokee County Health Officer to succeed the late *Dr. E. M. Moseley*, Rusk, who had held the position for many years, informs the Jacksonville *Progress*.

Dr. Clifford G. Swift, Cameron, has been reappointed county health officer of Milam County, reports the Cameron *Herald*.

Dr. O. P. Gandy, Lufkin, has been appointed to succeed *Dr. L. H. Denman* as health officer of Angelina County, states the Lufkin *News*. Dr. Gandy and *Dr. T. A. Taylor*, both of Lufkin, were appointed and *Dr. R. B. Forrest*, Huntington, was reappointed to the Angelina County Hospital board, thus creating an all-medical board, since three hold-over members are also physicians.

Dr. D. Price, Athens, has been reappointed county health officer, the Athens *Review* reports. Dr. Price is also city health officer.

Dr. J. Frank Clark, Georgetown, who has served the past two and one-half years as head of the Central Texas Health Department, has resigned to enter private practice, informs the Georgetown *Sun*.

Dr. Alvin L. Waller, formerly of Commerce, has assumed his duties as director of the Brazos County Health Unit in Bryan, the Bryan *Eagle* informs.

Dr. W. J. Allison, Dallas, has resigned as medical director of the Southwestern Life Insurance Company to enter private practice, reports the Brady *Standard*. *Dr. Howard E. Wiley*, Detroit, Mich., has been appointed medical director, and *Dr. C. Frank Brown*, Dallas, associate medical director.

Dr. Thomas A. King, Vernon, has retired from practice, reports the Vernon *Times*.

Dr. J. B. Lockhart, Brady, who celebrated his eighty-seventh birthday last December, has retired from the board of directors of the Brady National Bank, a post he has held since 1918, the Brady *Standard* states.

Dr. J. T. Harrington, Waco, celebrated his eighty-ninth birthday January 7 by making his usual rounds at the Baylor University girls' hospital and receiving patients at his downtown office, reports the Waco *Times-Herald*.

Dr. C. E. Wilson, Odessa, wrenched his back severely early in February when he was on a train en route to Dallas, according to the Wink *Bulletin*.

Dr. Wilson was lifting some heavy luggage as the train swerved, throwing him off balance. The resulting back injury necessitated his wearing a brace.

Dr. G. C. Lechenger, Houston, retired from active practice on January 1, at the same time retiring as roentgenologist at Jefferson Davis Hospital, where he has been head of the x-ray department since its establishment nine years ago. The Houston *Post* indicates that Dr. Lechenger will continue his position as associate professor of radiology at Baylor University College of Medicine.

Dr. J. N. Thomas, Mansfield, was honored on his ninetieth birthday January 12 with an open house given by his son and daughter-in-law, *Dr. and Mrs. Raymond Thomas*. More than three hundred guests registered, reports the Mansfield *News*.

Dr. David L. Hess, San Angelo, was 81 years old January 29, but spent the day without special celebration, informs the San Angelo *Standard*.

Dr. A. L. Hathcock, Palestine, was paid tribute in a surprise program given at the luncheon meeting of the Rotary Club February 5, states the Palestine *Herald and Press*. The veteran physician was commended in talks by four club members and was presented a Rotary emblem for his services to the club and to citizens of Anderson County.

Dr. E. H. Cary, Dallas, was honored on his seventy-fifth birthday February 28 with a dinner given by the Southwestern Medical Foundation, of which Dr. Cary is president. The Dallas *News* reports that Dr. H. H. Shoulders, Nashville, Tenn., president of the American Medical Association; Dr. Morris Fishbein, editor of *The Journal of the American Medical Association;* Dr. Charles Gordon Heyd, member of the A.M.A. Council on Medical Education and Hospitals; Dr. E. L. Henderson, president of the Southern Medical Association; and *Dr. John G. Young*, Dallas, president of the Dallas County Medical Society, were speakers at the dinner. Dr. Umphrey Lee, Dallas, president of Southern Methodist University, was toastmaster.

Miss Rose Rischar, Cameron, sister of *Dr. E. Rischar* and for many years nurse and superintendent of the Cameron Hospital, died January 4 after an illness of several months, according to the Cameron *Herald*.

Dr. and Mrs. Arthur Gleckler, Sherman, have announced the marriage of their son, *Dr. W. J. Gleckler*, to Miss Margaret Jean Larkin, Northampton, Mass. Young Dr. Gleckler is completing an internship at the Philadelphia General Hospital informs the Sherman *Democrat*.

Dr. and Mrs. I. C. Skinner, San Antonio, entertained with a cocktail party at the San Antonio Country Club during the recent International Post Graduate Medical Assembly of Southwest Texas, informs the San Antonio *Express*. Guests were physicians attending the assembly program, with Dr. and Mrs. Howard Kramer Gray, Rochester, Minn., as special honorees.

BIRTH

To *Dr. and Mrs. Carlos R. Hamilton*, Houston, a son, David Peyton, on December 24.

SOCIETY NEWS

Anderson-Houston-Leon Counties Society

January 7, 1947

(Reported by Leroy Trice, Secretary)

Anderson-Houston-Leon Counties Medical Society meeting January 7 in Palestine, elected officers as follows: John L. Dean, president; Harvey Bell, vice-president; Leroy Trice, secretary-treasurer; Harvey Bell, delegate; Fred E. Felder, alternate; Claude Joyce, censor; Paul Stokes and R. H. Hunter, hold-over censors. R. Q. Hunter, John T. Humphries, and Claude Joyce were appointed to the Public Relations Committee.

February 4, 1947

Endocrine Problems in the Female—Karl John Karnaky, Houston.

Karl John Karnaky, Houston, was speaker on the subject named above when Anderson-Houston-Leon Counties Medical Society met in Palestine on February 4.

Brazoria County Society

January 30, 1947

(Reported by A. O. McCary, Secretary)

Twelve members of Brazoria County Medical Society and their wives and five dentists and their wives met for dinner January 30 at the Dow Hotel, Freeport. Following the meal, the women adjourned to another room for their meeting. Herbert E. Merz, Alvin, president, presided over the medical society meeting. A national essay contest sponsored by the Association of American Surgeons and Physicians was discussed at length. Upon motion by G. J. Hayes, Alvin, the society decided to sponsor the contest in its area. Walter E. Cox, Angleton, moved that the society in its local essay contest offer a first prize of a $50 government bond, a second prize of a $25 bond, and a third prize of $10 cash. The motion passed unanimously. William C. Holt, Angleton, moved that Dr. Cox be selected to judge the essays for the medical society and contact the county judge and county superintendent of schools to help with the judging. The motion was passed unanimously. W. T. Galloway, Freeport; Dr. Merz, Alvin; Dr. Cox, Angleton; and W. M. Greenwood, West Columbia, were selected to work with the county superintendent in arousing interest in the contest.

Upon motion by Dr. Holt, the society agreed that the president should appoint a committee to map programs for the year. C. E. Fuste, Alvin, chairman; Ralph E. Gray, Lake Jackson; and Dr. Galloway were appointed to the committee. Dr. Fuste was granted permission to send each physician a letter requesting his favorite topic for discussion.

The society accepted the invitation of Dr. Mark E. Thompson, Dow Magnesium Hospital, Freeport, to meet with him the following month and hear a program arranged by him.

Brooks-Duval-Jim Wells Counties Society

January 15, 1947

Types of Leukemia—C. L. Behrns, Alice, and John H. Strickland, Alice.

Members of the Brooks-Duval-Jim Wells Counties Medical Society met in the office of G. G. Wyche in Alice on January 15. C. L. Behrns, Alice, and John H. Strickland, both of Alice, led a discussion on leukemia.

New officers were elected as follows: C. L. Behrns, Alice, president; John Veit, Falfurrias, vice-president; William H. Newkirk, secretary-treasurer; A. C. Duran, Corpus Christi, delegate; John H. Strickland, Alice, alternate; P. S. Joseph, Alice, and Crysup Sory, Freer, censors.

Prior to the meeting, members were served refreshments by Mrs. Wyche.

Brown-Comanche-Mills-San Saba Counties Society

January 13, 1947

(Reported by P. M. Wheelis, Secretary)

Physics Involved in Production of Head Injuries—George Enni, Temple

Surgical Aspects of Gastric Ulcer—Raleigh White, Temple.

Two guests from Temple presented the scientific program when Brown - Comanche - Mills - San Saba Counties Medical Society held a dinner meeting at Hotel Brownwood in Brownwood, January 13.

George Enni emphasized that some of the older concepts of the mechanism of production of head injuries are incorrect. He cited carefully controlled experiments which show that rotary motion imparted

to the head is a primary factor in producing brain damage.

Raleigh White stressed the importance of proper judgment in choosing treatment suitable for gastric ulcers when they are first encountered. He quoted statistics tending to show that gastric ulcer should be considered a dangerous lesion, no matter what its size or location. He advocated trial of medical treatment in selected cases of gastric ulcer.

February 10, 1947

(Reported by P. M. Wheelis, Secretary)

Evaluation of Rutin from a Study of the Literature—Morris Horn, Dallas.
Indications for Pulmonary Resection—Donald L. Paulson, Dallas.

Brown-Comanche-Mills-San Saba Counties Medical Society held a dinner meeting at Hotel Brownwood on February 10.

The scientific program outlined above was presented. It was concluded that an accurate evaluation of rutin awaits considerable further clinical trial, and that surgery of the chest has made such rapid development in recent years that now the risk of opening the chest compares favorably with opening the abdomen.

Upon motion by O. N. Mayo, Brownwood, seconded by E. J. Burns, Bangs, the society voted unanimously to go on record as approving passage of the basic science bill. The secretary was instructed to write a letter to each Senator and Representative of the district, informing them of the action taken by the society and enclosing a list of members of the society.

Dr. Mayo moved that the society sponsor an essay contest through the Association of American Physicians on the subject, "Why the Private Practice of Medicine Furnishes This Country with the Finest Medical Care." The motion carried.

Harry L. Locker, Brownwood, was elected delegate to succeed Dr. Ben M. Shelton, Brownwood, recently deceased.

S. Braswell Locker was unanimously elected to membership.

M. L. Fuller, the new director of the Brown County Health Unit, was introduced.

Cass-Marion Counties Society

January 8, 1947

(Reported by Jesse M. Brooks, Secretary)

Cass-Marion Counties Medical Society met at Linden, January 8, and chose the following offcers: E. W. Grumbles, Atlanta, president; Orval R. Taylor, Linden, vice-president; Jesse M. Brooks, Atlanta, secretary-treasurer; W. S. Terry, Jefferson, delegate; A. J. Woods, Jefferson; Joe D. Nichols, Atlanta; Jesse M. Brooks, Atlanta; and A. E. Starnes, Hughes Springs, alternates; and W. S. Terry, Jefferson; Orval R. Taylor, Linden; and M. J. Brooks, Jr., Atlanta, censors.

Cherokee County Society

January 28, 1947

(Reported by John Travis)

F.S.A. Hospital Insurance—F. L. Boutwell, State Health Officer, Farm Homes Administration.
Artificial Infant Feeding—Marvin Lamb, Jacksonville.

Cherokee County Medical Society held a dinner meeting at Nan Travis Hospital, Jacksonville, on January 28. Officers for 1947 were elected as follows: George M. Hilliard, Jacksonville, president and delegate; James S. Scarborough, Rusk, vice-president; T. H. Cobble, Rusk, secretary-treasurer.

F. L. Boutwell, state health officer for the Farm Homes Administration, was introduced by the county representative for F.H.A., R. L. Payne. Mr. Boutwell discussed hospital insurance in connection with the F.H.A. program.

Marvin Lamb, Jacksonville, presented a paper on artificial infant feeding, which was discussed generally.

Catherine Armstrong, formerly of Ponca City, Okla., who came to Jacksonville to be associated as pediatrician with the Travis Clinic, was introduced.

Eastland-Callahan Counties Society

February 11, 1947

(Reported by M. L. Stubblefield, Secretary)

Eclampsia—Guy L. Patillo, Abilene.
Virus Pneumonia—Erle D. Sellers, Abilene.

Eastland-Callahan Counties Medical Society met February 11 at Eastland for a dinner served by the local physicians. The scientific program outlined above was presented.

Decision was made to send telegrams to state Representatives in behalf of the basic science bill.

C. T. Cole, Gorman, was elected to membership, making the seventh such addition since VJ-Day. J. W. Varner, Abilene, was a guest.

The meeting date for the society has been changed to the third Tuesday bimonthly.

Ector-Midland-Martin-Howard-Andrews-Glasscock Counties Society

January 13, 1947

Approximately thirty members and guests of Ector - Midland - Martin - Howard - Andrews - Glasscock Counties Medical Society met January 13 at the Settles Hotel, Big Spring, as guests for dinner of the Big Spring members. Members of the auxiliary and the medical society held separate meetings after the meal.

Ellis County Society

February 12, 1947

(Reported by B. C. Wallace, Jr., Secretary)

Pernicious Anemia—J. B. Harris, Midlothian.

Seventeen members of Ellis County Medical Society met in the lunchroom of the Waxahachie Sanitarium, February 12. J. B. Harris, Midlothian, presented a paper on pernicious anemia, which was discussed by S. H. Watson, W. C. Tenery, and B. C. Wallace, all of Waxahachie.

A letter from R. A. Miller, San Antonio, member of the Public Relations Committee of the State Medical Association, was read. In accordance with suggestions in the letter, the society voted to telegraph Ellis County Legislators in support of the basic science bill.

S. H. Watson reported that the City Federation of Women's Clubs will support the ten-point program of public health in Ellis County as proposed by the medical society. It was voted to write the Federation a letter of thanks.

Ben Stein, Ferris, was unanimously elected to membership.

El Paso County Society

(Reported by W. Compere Basom, Secretary)

The El Paso Tumor Clinic, the first tumor clinic in the United States sponsored by a county medical society, has been reactivated following the war and is functioning under the sponsorship of the El Paso County Medical Society. It is approved by the American Cancer Society, and is receiving financial assistance from that organization through its Texas Division.

Falls County Society

February 10, 1947

(Reported by Neil Buie, Jr., Secretary)

Treatment of Prostatic Hypertrophy—H. A. O'Brien, Dallas.

Seventeen members and five guests of the Falls County Medical Society met February 10 in the Blue Room of the Falls Hotel, Marlin, for dinner and a paper on prostatic hypertrophy by H. A. O'Brien, Dallas urologist.

Dr. O'Brien pointed out that prostatic hypertrophy is essentially a manifestation of aging. He em-

phasized the use in diagnosis of bimanual palpation of the gland and the use of the cystogram. He believes that residual urine of 1 to 4 ounces is not important, but that it becomes important if it reaches 1 to 2 pints. He does not use catheter drainage for periods of more than 4 to 6 days. He prefers to do a suprapubic cystostomy and allow the bladder to regain its normal tone.

One of the first Texas physicians to use transurethral resections in removing the prostate, Dr. O'Brien mentioned two contraindications for that procedure: marked enlargement of the prostate and ankylosis of the hip. The preoperative preparation of the patient for transurethral resection is as important as for removal of the prostate by enucleation. In the operation itself it is essential that the surgeon be thoroughly acquainted with the anatomy of the male posterior urethra, and that he completely remove the gland. The danger of removing too much tissue was emphasized.

Because of the size of the instrument and the possibility of postoperative stricture, Dr. O'Brien believes that routine dilation of the urethra should be done every other day. His conclusion was that transurethral resection is the method of choice in the treatment of prostatic hypertrophy.

Gregg County Society

Januray 14, 1947

(Reported by John E. Wensley, Secretary)

Twenty-two members of Gregg County Medical Society met January 14 at Jimmie's Restaurant in Longview for dinner and a business meeting, presided over by E. O. Watkins, Greggton, president.

Election of officers was held. Garland S. Rushing, Longview, was elected president; Seth Downs, Kilgore, vice-president; John E. Wensley, Longview, reelected secretary-treasurer; Joe D. Roberts, Longview, delegate; and V. R. Hurst, Longview, alternate.

Joe Roberts, Longview, reported a conversation with Representative Cecil Storey, and urged that telegrams be sent to Legislators in favor of passage of a basic science measure. Upon motion by Bain Leake, Gladewater, seconded by Morris Welinsky, Kilgore, the society directed its secretary to send such telegrams. H. H. Niehuss, Longview, moved that the secretary send a card to each member of the society reminding him to send a telegram individually to each Legislator urging passage of the basic science bill. Upon second by Dr. Downs, the motion passed.

Dr. Leake reported that the Gregg County Commissioners propose to erect a building on the grounds of Gregg County Hospital for the use of the Gregg County Tuberculosis Association, and that the Tuberculosis Association has purchased an x-ray machine for use in the building. The state mobile x-ray truck was scheduled to be in Gregg County in February to make 10,000 chest roentgenograms. Dr. Rushing moved, seconded by Hardy Cook, Longview, that a committee of five physicians be appointed by the president to meet with the Tuberculosis Association and make a study of the proposed plan, and point out the possibilities of combining existing equipment with that to be purchased. The motion carried. Drs. Rushing, Hurst, Downs, Leake, and Louis Markham, Longview, were appointed to the committee.

The secretary was instructed to send a letter of thanks to George Tate, Longview, for securing several fine medical programs for the society given by Dallas physicians.

Hays-Blanco Counties Society

February 13, 1947

(Reported by J. R. de Steiguer, Secretary)

The Basic Science Bill—R. T. Wilson, Austin.
Considerations of Intestinal Obstruction—A. R. McComb, San Antonio.
Head Injuries—Ralph Munslow, San Antonio.
Skin Cancers—J. D. Wilson, Austin.

Hays-Blanco Counties Medical Society was host February 13 in San Marcos to members of the Caldwell, Gonzales, and Guadalupe Counties Medical Societies at a chicken dinner and scientific program, as outlined above. Forty-one physicians and one visitor were present.

The four medical societies have banded together to meet once every two months. The next meeting will be in Seguin in April.

The Hays-Blanco Society is sponsoring a local contest, with prizes of $25, $15, and $10 for essays by junior and senior high school students on the subject "Why the Private Practice of Medicine Furnishes This Country with the Finest Medical Care."

Hidalgo-Starr Counties Society

February 13, 1947

(Reported by Lloyd M. Southwick, Secretary)

Around the Clock Fractures—Marion R. Lawler, Mercedes.
Sulfathalidine (motion picture).

Hidalgo-Starr Counties Medical Society met February 13 at the Mercedes High School Cafeteria. Marion R. Lawler, Mercedes, discussed various fractures, discussing particularly the causes for delayed union and nonunion.

A sound, color motion picture film on sulfathalidine, prepared by Sharpe and Dohme, was shown. The film deals with the use of sulfathalidine in the treatment of chronic ulcerated colitis and shows the nontoxicity of the drug and its efficacy in treating this condition.

Jefferson County Society

January 13, 1947

(Reported by Lamar C. Bevil, Secretary)

Jefferson County Medical Society met January 13 at St. Therese Hospital, Beaumont, for a business meeting.

W. D. Brown, Beaumont, discussed the importance of writing and wiring legislators to prompt passage of the basic science bill.

Dr. Brown and John N. Gardner, Beaumont, discussed the functions of the National Physicians Committee and its relation to the American Medical Association. C. M. White, Beaumont, discussed the interrelations of the National Physicians Committee and the Texas Physicians Committee.

Letters were read regarding the need of a psychiatrist in Beaumont. John A. Hart, L. C. Bevil, and L. T. Pruit, all of Beaumont, discussed the matter. Dr. Pruit moved that the society endorse the need for psychiatric facilities in the Baptist Memorial Hospital. The motion was amended by Wallace Byrd, Beaumont, to indicate that the need is far in excess of the four-bed ward mentioned in one of the letters. The motion as amended carried.

Dudley M. English, Beaumont, reported for the committee on industrial medicine and hygiene, that the Petroleum Institute has appointed a committee to study the carcinogenic effect of petroleum, and that he is one of the members of the committee.

Letters were read from the New Orleans Graduate Medical Assembly announcing its meeting, Lamar College thanking the society for its subscription to *The Journal of the American Medical Association*, and from the postgraduate division of the University of Texas Medical Branch announcing a course in physical medicine.

Eugene H. Lindsey, Beaumont, announced that the Beaumont Medical Dispensary is going to close in June. A discussion brought out the fact that the Community Chest, which has operated the dispensary, believes the dispensary is a problem for the city, but that members of the society consider operation of the dispensary by the Community Chest might be continued. Upon motion by Dr. Lindsey,

the society voted to send a committee to discuss the problem with the Community Chest.

M. A. Cunningham, Beaumont, reported that the Texas Tuberculosis Association is attempting to secure legislation providing for increased hospital beds for tuberculosis patients in Texas.

Application of Roland B. Anderson, Port Arthur, for transfer of membership from the Orange County Medical Society was approved.

February 10, 1947

(Reported by Lamar C. Bevil, Secretary)

Approximately forty were present for the February 10 meeting of Jefferson County Medical Society in St. Mary's Hospital Nurses Home, Port Arthur. D. M. English, Beaumont, president, presided.

L. C. Powell, Beaumont, related his experience with an indirect inguinal hernia.

G. B. Stephenson, Beaumont, reported on meetings in Chicago of the American Society for Surgery of the Hand and of the American Academy of Orthopedic Surgeons.

T. A. Fears, Beaumont, chairman of the legislative committee, opened a discussion of the basic science bill, now pending before the State Legislature. L. C. Heare, George Sladczyk, and L. R. Byrd, Jr., all of Port Arthur, and Lamar C. Bevil, W. J. Graber, and C. L. Pentecost, all of Beaumont, entered into the discussion. The necessity of communicating with representatives in the Legislature was emphasized. Upon motion by Thomas M. Tyndall, Beaumont, seconded by Eugene H. Lindsey, Beaumont, and amended by C. L. Pentecost, it was agreed that the facts concerning the basic science bill should be presented in the newspapers. The secretary was instructed to advise each member of the society of the names and addresses of Jefferson County Legislators. A motion was made by Bennie J. Fett, Port Arthur, seconded by L. R. Byrd, Jr., Port Arthur, that each member be furnished five form letters to be sent to each of the four Legislators. An amendment was made by L. C. Powell, seconded by Dr. Sladczyk, that 5,000 form letters be printed. The amended motion passed.

Dr. English announced that the management of the James K. Leitner Home for Crippled Spastic Children had requested the society to endorse its work. Upon motion by Dr. Graber, seconded by Dr. Fears, it was agreed that a committee should investigate the work being done by the home and reports its results and recommendations to the society. John A. Hart, Robert B. Stevens, Paul N. Fortney, and G. B. Stephenson, all of Beaumont, were named to the committee.

The secretary announced the appointment of E. Mittendorf as executive secretary, and read the names of members of the standing committees for 1947, as follows: *legislative and public health*, T. A. Fears, Beaumont (chairman); A. R. Autrey, Port Arthur (cochairman); B. H. Davison, Port Arthur; Eugene H. Lindsey, Beaumont; P. T. Weisbach, Nederland; *program*, L. T. Pruit, Beaumont (chairman); Thomas B. Matlock, Port Arthur (cochairman); Roy Young, Port Arthur; R. H. Engledow, Beaumont; *hospital*, B. H. Vaughan, Port Arthur (chairman); W. P. Killingsworth, Port Arthur; Robert B. Stevens, Beaumont; *public relations*, Bennie J. Fett, Port Arthur (chairman); I. G. Wilson, Beaumont (cochairman); Max J. Knight, Port Arthur; W. J. Graber, Beaumont; *economics*, Fred Colby, Beaumont (chairman); John A. Hart, Beaumont; B. F. Pace, Nederland (cochairman); R. B. Carroll, Port Arthur; *industrial medicine and hygiene*, George Sladczyk, Port Arthur (chairman); John N. Gardner, Beaumont (cochairman); F. G. Williams, Beaumont; James W. Long, Port Arthur; J. C. Hines, Nederland; *tuberculosis*, M. A. Cunningham, Beaumont (chairman); W. A. Newton, Beaumont; Fred Y. Kuhlman, Port Arthur; Irma M. McFaddin, Port Arthur; John W. Torbett, Jr., Beaumont; *cancer*, Ray R. Orrill, Port Arthur, (chairman); J. M. White, Port Arthur; R. E. Barr, Beaumont; R. B. Williford, Beaumont; *heart*, H. G. Bevil, Beaumont (chairman); Louian C. Carter, Port Arthur (cochairman); Paul N. Fortney, Beaumont; B. B. Elster, Port Arthur.

The secretary read letters from the American College of Chest Physicians, the office of Naval Officer Procurement, and a letter of thanks from Mrs. Joseph Record, whose husband, Dr. Joseph Record, Beaumont, died recently.

Karnes-Wilson Counties Society

January 10, 1947

Karnes-Wilson Counties Medical Society elected officers January 10 in Floresville. The following were chosen: John V. Blake, Jr., Floresville, president; C. C. Quillian, Kenedy, vice-president; S. R. Boykin, Floresville, secretary-treasurer.

Lubbock-Crosby Counties Society

February 4, 1947

(Reported by O. R. Hand, Secretary)

Psychoneurosis—George K. Swartz, Plainview.

Lubbock-Crosby Counties Medical Society met February 4 at the Plains Clinic, Lubbock, with President Pauline Miller, Lubbock, presiding. Twenty-five members and seven visitors were present. Among the visitors were H. H. Latson, Councilor of the Third District; E. A. Rowley, Trustee of the State Medical Association; and G. L. Powers, secretary of the Third District Medical Society, all of Amarillo; C. A. Rosebrough, Sweetwater; and W. C. Hill and A. H. Daniell, Brownfield.

The scientific paper named above was presented.

Dr. Latson introduced the problem of possible redistricting of the state, and explained several plans. Drs. Rowley, Powers, and Rosebrough also spoke on the subject. Upon motion by Allen T. Stewart, Lubbock, seconded by Roy G. Loveless, Lubbock, the society voted to recommend that the boundaries of the Third District remain unchanged, but that additional territory which might be added advantageously would be acceptable. The secretary was directed to send copies of the motion, which carried, to G. V. Brindley, Temple, chairman of the committee directed to recommend redistricting plans; Holman Taylor, Fort Worth, Secretary of the State Medical Association; C. C. Cody, Jr., Houston, President of the State Medical Association; Dr. Rowley, and Dr. Latson.

Upon motion by Dr. Stewart, seconded by M. H. Benson, Lubbock, the society voted to have its charter framed.

Dr. Loveless requested those who plan to present papers at the annual session of the State Medical Association to inform him so that the papers can be read first before the county society.

O. G. Barsh stated that the Red Cross had approached him concerning a first aid course to be given to ambulance drivers by the Red Cross. No action was taken by the society.

The secretary read several communications.

Navarro County Society

February 3, 1947

A. L. Grizzaffi, Frost, was principal speaker when the Navarro County Medical Society met at the city hall, Corsicana, on February 3. Thirteen members were present, and G. H. Sanders, Kerens, president, presided.

Monthly meetings of the society have been resumed following interruption during the war.

Nueces County Society

January 14, 1947

Transfusion and Infusion Reactions—H. J. Schattenburg, San Antonio.

Nueces County Medical Society, meeting January 14 at Memorial Hospital, Corpus Christi, recommended R. S. Knapp as city physician to be in charge of examination of food handlers and C. P. Jasperson for appointment to the board of health.

Following presentation of the paper named above, committees were appointed as follows: *hospital and medical service*, W. C. Triplett (chairman), C. S. Larson, Charles Mella; *football*, O. E. Marler; *library*, C. D. Stewart (chairman), L. C. Garrett, S. K. Stroud; *insurance*, C. M. Williamson (chairman), T. E. Edwards, R. J. Sigler; *legislative*, Y. C. Smith (chairman), Hugh Kennedy, N. D. Carter; *public relations*, J. C. Sharp (chairman), A. J. Ashmore, R. L. Garrett; *public health*, Foy Moody (chairman), George O'Byrne, C. P. Jasperson, J. Nast; *program*, Jack Giles (chairman), John Sloan, L. C. Arnim; *cancer*, Gordon Heaney (chairman), W. C. Triplett.

Palo Pinto-Parker Counties Society

January 14, 1947

Emergency Treatment of the Eyes and Ears—C. R. Williams, Mineral Wells.

Eleven physicians were present at the January 14 meeting of Palo Pinto-Parker Counties Medical Society at the Nazareth Hospital, Mineral Wells. C. R. Williams, Mineral Wells, presented a paper on emergency treatment of the eyes and ears, and the subject was discussed generally.

Pecos-Jeff Davis-Presidio-Brewster Counties Society

February 2, 1947

(Reported by W. E. Lockhart, Secretary)

Five members of the Pecos-Jeff Davis-Presidio-Brewster Counties Medical Society and four of their wives were present for a meeting February 2 at the Crews Hotel, Marfa, as guests of J. P. Searles and Louis Cartall, Jr.

A round-table discussion followed a short business meeting in which the membership of Dr. Cartall was unanimously approved.

Randall-Deaf Smith-Parmer-Castro-Oldham Counties Society

February 5, 1947

(Reported by Robert P. Jarrett, Secretary)

Anemia—Millard Nobles and R. R. Wills, Hereford.
Differential Diagnosis of Anemia: Case Report—Lewis B. Barnett, Hereford.

Every member of the Randall-Deaf Smith-Parmer-Castro-Oldham Counties Medical Society was present for a meeting in the Deaf Smith County Hospital, Hereford, on February 5. Twelve physicians and a visiting dentist from Canyon attended.

A program on anemia was presented by Millard Nobles, R. R. Wills, and Lewis B. Barnett, all of Hereford.

It was agreed that each member of the society should write to Legislators from the district, thanking them for their support of the basic science bill.

Application of Carl Jordan, Dimmitt, for membership in the society was approved.

Tarrant County Society

January 21, 1947

(Reported by W. P. Higgins, Jr., Secretary)

Biographical Sketch of Dr. Bacon Saunders—J. T. Tucker, Fort Worth.
Cases of Carcinoma of the Colon—R. G. Baker, Fort Worth
Treatment of Carcinoma of the Rectum—F. L. Snyder, Fort Worth.

Tarrant County Medical Society met January 21 in the Medical Arts Auditorium, Fort Worth, with seventy-six members and five visitors present.

William M. Crawford, Fort Worth, was in charge of the scientific program outlined above. The paper by Dr. Baker was discussed by Dr. Crawford, R. J. White, and T. H. Thomason, all of Fort Worth. The paper by Dr. Snyder was discussed by Dr. Crawford, W. C. Tatum, and Frank G. Sanders, all of Fort Worth.

L. H. Reeves, member of the Legislative Committee of the State Medical Association, and R. G. Baker, Councilor of the Thirteenth District, talked on the basic science bill and asked that members of the society write to Representatives and Senators urging passage of the measure. It was requested that the physicians explain the bill to each of their patients and suggest that they also write to the Legislators.

Dr. Baker announced a meeting of the Thirteenth District Medical Society in Abilene in the spring. He asked that members who plan to be present arrange to spend the preceding night in Abilene in order to attend an entertainment given by the Taylor-Jones Counties Medical Society.

Robert H. Bickel, Ralph E. Campbell, Francis J. Daugherty, Harold B. Mindell, and Hugh W. Savage were elected to membership upon application.

Tributes were paid to Dr. R. B. Anderson and Dr. W. B. Nies, Fort Worth physicians who died in January.

Taylor-Jones Counties Society

February 11, 1947

Is the Orthodox Therapy of Rheumatic Fever Conducive to Psychosomatic Disability?—W. B. Adamson, Abilene.

Taylor-Jones Counties Medical Society, meeting February 11 at the Wooten Hotel, Abilene, agreed to write Legislators, both as a group and as individuals, in support of the proposed basic science bill.

W. B. Adamson, Abilene, spoke on rheumatic fever, emphasizing the care which must be exercised in using orthodox methods of treatment so that the patient will not on the one hand come to consider himself an invalid and sink into a psychopathic mental state and on the other hand will not believe himself so healthy that he harms himself. In a general discussion, several physicians recommended occupational therapy as a means to prevent undue anxiety on the part of the patient.

R. G. Baker, Fort Worth, Councilor of the Thirteenth District, made a brief talk on the objectives of the State Medical Association for the year.

The society nominated B. F. Rhodes, J. M. Alexander, and W. H. Barnett, all of Abilene, and F. E. Hudson and Dallas Southard, both of Stamford, for honorary membership.

D. G. Strole, Abilene, was elected to membership.

Plans for the April 22 meeting of the Thirteenth District Medical Society in Abilene were discussed.

Tom Green-Eight County Society

January 6, 1947

(Reported by H. M. Anderson, Secretary)

Experimental and Clinical Atelectasis—W. W. Coulter, Sanatorium.
Suggestions for Better Utilization of Inadequate Bed Facilities at the State Sanatorium—R. C. Bernard, Sanatorium.

Approximately forty members and guests of the Tom Green-Eight County Medical Society were entertained with dinner at the State Tuberculosis Sanatorium, January 6. J. B. McKnight, superintendent, and his staff were given a rising vote of thanks by the society for the dinner and program.

W. W. Coulter, Sanatorium, read a paper on atelectasis, illustrated by roentgenograms of dogs in which experimental atelectasis had been produced by inserting plugs into the bronchi. The clinical picture and management of postoperative atelec-

tasis was discussed, emphasis being placed on early bronchoscopy. M. W. Everhart, W. D. Anderson, Jerome Smith, W. Grady Mitchell, Gordon F. Madding, and Carl A. Kunath, all of San Angelo, discussed the paper.

R. C. Bernard, Sanatorium, gave an outline of statistics on the number of active cases of tuberculosis, deaths, and mortality rates in Texas. He stressed early correct diagnosis, and suggested that only patients with positive sputa be admitted to the State Sanatorium. His paper was discussed by James White, San Angelo.

Upon motion by W. D. Anderson, seconded by Ben L. Boynton, San Angelo, the society voted to recommend to the State Medical Association that David L. Hess, San Angelo, be made an honorary member.

February 3, 1947

Carcinoma of the Stomach—H. M. Williams, San Angelo.
Acute Laryngo-Tracheo-Bronchitis—M. W. Everhart, San Angelo.

The two papers named were presented before the Tom Green-Eight County Medical Society when it met at Hotel Cactus, San Angelo, on February 3.

Wharton-Jackson-Matagorda-Fort Bend Counties Society

January 14, 1947

Abdominal Pains in Children.
Medical Aspects—George W. Salmon, Houston.
Surgical Aspects—Granville Q. Adams, Houston, and L. B. Outlar, Wharton.
Allergic Aspects—F. R. Rugeley, Wharton.

Dinner was served to members of the Wharton-Jackson-Matagorda-Fort Bend Counties Medical Society and Auxiliary in the banquet hall of the Methodist Church in Wharton, January 14. The auxiliary adjourned to another meeting place, and the medical society heard a discussion of various aspects of abdominal pains in children.

L. B. Johnson, El Campo, president, presided over a business session in which G. L. Davidson and J. M. Andrews, both of Wharton, were elected to honorary membership in recognition of their long years of service.

Wilbarger County Society

January 14, 1947

Officers were elected by the Wilbarger County Medical Society in Vernon, January 14. Those named, all of Vernon, include Joe Shipman, president; B. W. Miller, vice-president; J. L. Restivo, secretary-treasurer; A. L. Borchardt and J. J. Muirhead, delegates.

Williamson County Society

February 11, 1947

Surgical Treatment of Lesions of the Thoracic Cardiovascular System and Esophagus—G. V. Brindley, Temple.

G. V. Brindley, Temple, was guest speaker when Williamson County Medical Society met in Taylor, February 11. His subject is named above.

Wood County Society

January 14, 1947

(Reported by James W. Williams, Secretary)

Skin Cancer—J. B. Howell, Dallas.
Hernias—Sidney Gault, Dallas.

Nine members of Wood County Medical Society met in Mineola on January 14 for the program outlined above. In addition to the two speakers from Dallas, H. O. Thompson, C. B. Young, and Thomas M. Jarmon, all of Tyler, were guests.

Eleventh District Society

March 14, 1947

(Reported by C. B. Young, Secretary)

The Eleventh District Medical Society met at the Blackstone Hotel, Tyler, on March 14, for the following scientific program:

Allergy in General Medical Practice—A. Ford Wolf, Temple.
Discussion—E. G. Faber, Tyler.
Indications for Pulmonary Resection—Donald L. Paulson, Dallas.
Discussion—Fred Felder, Palestine.
Management of Chronic Uterine Hemorrhage—Don G. Harrell, Dallas.
Discussion—J. J. Faust, Tyler.
Luncheon: Round-Table Discussion of Hypertension: Medical and Surgical Treatment—Tyler Internists Club.
The Obstructed Bladder Neck—A. Keller Doss, Fort Worth.
Discussion—Leroy Trice, Palestine.
Proctology in Relation to General Medicine—Newton D. Smith, Rochester, Minn.
Discussion—E. H. Caldwell, Tyler.

Arrangements were made for C. C. Cody, Jr., Houston, President of the State Medical Association, to speak to the Tyler Kiwanis Club at luncheon.

Thirteenth District Society

April 22, 1947

(Reported by Robert C. Stokes, Secretary)

Thirteenth District Medical Society will meet April 22 at Hotel Wooten, Abilene, for the scientific program announced below. Plans are being made by Taylor-Jones County Medical Society to entertain visitors the evening of April 21. Those who plan to attend the meeting are therefore requested to arrange to spend the night in Abilene.

The program, scheduled to begin at 10 a. m., will be as follows:

Endocrine Therapy in Gynecology—Theron Funk, Fort Worth.
Discussion—C. C. Cartwright, Breckenridge.
Management of Intestinal Obstruction—Joe White, Fort Worth.
Discussion—James Darwin, Decatur.
Surgery of the Senile Hip—W. H. Ledbetter, Wichita Falls.
Discussion—Louis J. Levy, Fort Worth.
Luncheon.
Modern Treatment of Syphilis—Earl Cockerell, Abilene.
Discussion—J. Franklin Campbell, Fort Worth.
Treatment of the Anemias—J. R. Mast, Wichita Falls.
Discussion—L. J. Webster, Abilene.
An Obstetrical Subject—J. J. Muirhead, Vernon.
Discussion—J. E. Kanatser, Wichita Falls.

Frank Hodges, Abilene, is president of the society; Robert C. Stokes, Fort Worth, is secretary.

AUXILIARY NOTES

Officers of the Woman's Auxiliary to the State Medical Association of Texas: President, Mrs. George Turner, El Paso; President-Elect, Mrs. Edward C. Ferguson, Beaumont; First Vice-President, Mrs. L. B. Windham, Tyler; Second Vice-President, Mrs. V. M. Longmire, Temple; Third Vice-President, Mrs. R. E. Clark, Memphis; Fourth Vice-President, Mrs. J. E. Hogan, Big Spring; Corresponding Secretary, Mrs. Robert F. Thompson, El Paso; Recording Secretary, Mrs. M. A. Ramsdell, San Antonio; Publicity Secretary, Mrs. J. F. Campbell, Fort Worth; Treasurer, Mrs. Guy Jones, Dallas; Parliamentarian, Mrs. Joe Nichols, Atlanta.

The Annual Meeting of the Woman's Auxiliary to the American Medical Association will be held in Atlantic City, N. J., June 9-13, in conjunction with the meeting of the American Medical Association. Haddon Hall will be headquarters for the auxiliary, and a program of interest to visiting women is being planned. As the American Medical Association will be celebrating its centennial anniversary, special features are being arranged for its program, and auxiliary members will be invited to take advantage of some of these attractions.

Requests for reservations, which should be made as promptly as possible, should be sent to Dr. Robert A. Bradley, Chairman, Subcommittee on Hotels, 16 Central Pier, Atlantic City, N. J.

AUXILIARY NEWS

Brazoria County Auxiliary met January 30 at the Dow Hotel, Freeport, for dinner with the medical society, followed by a separate business session and social hour with Mrs. G. J. Hays, Alvin, presiding.

Twelve members were present for the installation of officers elected at the December meeting. Those installed include Mesdames G. J. Hayes, Alvin, pres-

ident; S. B. Slaughter, Freeport, first vice-president; W. G. Ryan, Freeport, second vice-president; H. K. May, Lake Jackson, third vice-president; H. L. Shaw, Freeport, secretary; William C. Holt, Angleton, treasurer; and W. E. Cox, Angleton, corresponding secretary. A parliamentarian, Mrs. J. S. Montgomery, Angleton, and a program chairman, Mrs. W. M. Greenwood, West Columbia, were added at the January meeting.

The auxiliary voted to send letters to its Legislators urging support of the basic science and revised medical practice act bills.

A vote of thanks was extended to Mrs. Greenwood, retiring president, for the luncheon in her home honoring Mrs. George Turner, El Paso, State Auxiliary President, during her visit recently.—Mrs. W. E. Cox, Corresponding Secretary.

El Paso County Auxiliary celebrated its twenty-fifth anniversary at its February 10 meeting in the Turner Memorial Home, El Paso. Following a program at which Mrs. Louis W. Breck spoke on "Medical Ethics for Doctors' Wives" and Mrs. Glenn R. Northup, administrator of Red Cross volunteers for special services of the midwestern area, spoke on "Community Services," a silver tea was held. Mrs. John E. Morrison was chairman of arrangements.

Hostesses for the tea hour were past presidents of the auxiliary as follows: Mesdames C. M. Hendricks, George Brunner, K. D. Lynch, B. F. Stevens, Paul Gallagher, W. L. Brown, Ralph Homan, George Turner, T. C. Lydell, F. O. Barrett, J. W. Laws, A. D. Long, Orville Egbert, Jacob Rogde, William J. Davis, and Robert F. Thompson.

The El Paso auxiliary was organized in February, 1922, by the late Mrs. R. B. Homan, Sr., with a charter membership of 63. While increasing its membership to a present total of 144, the auxiliary has participated in many activities outside its immediate field of endeavor. The group annually contributes to the Christmas cheer of patients in the tuberculosis wards of the City-County Hospital; supports antituberculosis work; cooperates with city and county authorities in efforts to improve local civic and health conditions; and supports the Community Chest, American Red Cross, and March of Dimes campaigns. During World War II, the auxiliary as a unit sewed for the Red Cross, and individual members served as Gray Ladies, sold bonds, and knitted.—Mrs. J. D. Martin, Publicity Chairman.

Mrs. Bertha H. Bush, resident of El Paso, Texas, for forty-eight years and for many years a member of the El Paso County Auxiliary, died suddenly January 14, 1947, while visiting friends in Pecos. Mrs. Bush was the wife of the late Dr. I. J. Bush, El Paso physician.

Galveston County Auxiliary entertained Mrs. George Turner, El Paso, President of the State Auxiliary, at its luncheon meeting January 17 in the Buccaneer Hotel, Galveston. Mrs. Turner urged members to acquaint themselves with pending bills affecting the medical profession, pointed out the aims of the auxiliary, and offered suggestions for the next year's program. Mrs. C. H. Gilliam, treasurer, presided in the absence of Mrs. John L. Otto, president, who was out of the city. Approximately sixty were present for the luncheon.—Mrs. John L. Otto, President.

Hidalgo-Starr Counties Auxiliary met at Mercedes in the home of Dr. Marion R. Lawler on February 13. Miss Zara Thigpen, McAllen, recounted the experiences of an expedition into Chiapas, Mexico, to study Indian tribes in that region.

Jefferson County Auxiliary at its luncheon meeting January 22 in Port Arthur heard Mrs. George Turner, El Paso, President of the State Auxiliary, discuss the aims and purposes of the organization. Orange County Auxiliary members were guests at the luncheon, which was attended by approximately fifty women. Mesdames F. J. Beyt, I. T. Young, B. J. Fett, and Clifford Painton, Port Arthur, were hostesses.

Dr. E. C. Ferguson, Beaumont, spoke on the basic science bill when Jefferson County Auxiliary met in Beaumont on February 5. The talk was given at a morning coffee at Hotel Beaumont.—Mrs. G. R. Solis, Publicity Secretary.

Johnson County Auxiliary met January 8 at the home of Mrs. O. T. Smyth, Cleburne. Mrs. O. T. Smyth, Jr., Alvarado, was hostess to nine guests. Mrs. B. H. Turner, Cleburne, president, presided over a business session in which new officers, to be installed in May, were elected. Those chosen include Mrs. J. W. Pickens, president-elect, and Mrs. M. T. Knox, secretary-treasurer. Mrs. J. G. Little will become president. Mrs. J. W Pickens led a discussion on medical ethics, at the close of which a salad course was served.

McLennan County Auxiliary met for a morning coffee January 22 at the Morris Tea Room, Waco. Sixty women, including ten wives of Veterans Hospital physicians, were present to hear Mrs. J. R. Gilliam, Mart, review "The Autobiography of the Mayo Brothers." Mrs. R. J. Hanks, Waco, was appointed by the president, Mrs. R. E. Bullard, Waco, to represent the auxiliary on the Community Chest council.

Hostesses were Mesdames F. F. Kirby, M. A. Magid, H. E. Hipps, I. Warner Jenkins, Neill Simpson, A. O. Manske, Tom L. Husbands, J. R. Gilliam, and C. F. Miller. Mesdames Manske and Husbands presided at the tea and coffee services, which rested on a table decorated in the western motif, centered with cacti.—Mrs. F. F. Kirby, Publicity Chairman.

Taylor-Jones County Auxiliary heard a talk on public health measures by Dr. David Cowgill, director of the Abilene-Taylor County Health Unit, at its meeting January 14 in the home of Mrs. James P. Bridges, Abilene. Approximately twenty-five were present for the meeting, which was presided over by Mrs. Erle Sellers, Abilene, president. Hostesses were Mesdames Bridges, Jack Crow, J. D. Magee, J. B. Latham, and J. M. Estes.

Tom Green-Eight County Auxiliary entertained with a luncheon February 3 at Hotel Cactus, San Angelo. Mrs. George Turner, El Paso, President of the State Auxiliary, spoke on the auxiliary organization and program. She urged contributions to the library fund and the establishment of a speakers bureau for lay clubs. She asked that each member study the ten-point plan for medical service of the American Medical Association and the basic science bill now pending in the Texas Legislature.

Mrs. R. M. Arledge, president, reported that the auxiliary had collected $80.50 for the March of Dimes campaign. She introduced Mrs. George Gray and Mrs. Barney Grafa as new members.

New officers were elected as follows: Mesdames W. Grady Mitchell, president; Louis K. Tester, first vice-president; W. C. Hixson, second vice-president; W. B. Butner, secretary; Merrill W. Everhart, treasurer; Maynard Knight, publicity secretary; and Victor Schulze, parliamentarian.

The invocation was delivered by Mrs. Mitchell.

Mesdames Gordon Madding, Jerome Smith, T. F. Carbrey, and Lacy Smith were hostesses.

Mrs. Turner was also the honored guest when the auxiliary entertained with an informal cocktail party at the home of Mrs. R. M. Finks on February 3.—Mrs. Victor Schulze, Publicity Secretary.

Wharton-Jackson-Matagorda-Fort Bend Counties Auxiliary had dinner with the medical society at the

Methodist Church, Wharton, on January 14, after which the women adjourned to the home of the president, Mrs. Jarrett Williams. During the business meeting emphasis was placed on the yearly objectives as outlined by the State Auxiliary President, Mrs. George Turner, El Paso. Plans were made and committees appointed to carry out these objectives. Mrs. W. S. Thiltgen, assisted by Mrs. Vernon Black, entertained at a social hour.—Mrs. B. M. McGee, Secretary.

Wichita County Auxiliary held an open meeting January 23 at the Hardin College Auditorium, Wichita Falls. The speaker was Mrs. Rex Fortenbury, Beaumont, an attorney, who discussed "What Socialized Medicine Means to You." Mrs. Fortenbury has made a special study of current legislative measures and how they may apply to the general welfare of the public.—Mrs. E. Aubrey Cox, Publicity Secretary.

Twelfth District Auxiliary met January 14 at the First Baptist Church, Temple, when the medical society was in session. Thirty-seven members and visitors were present for the business meeting at which the president, Mrs. G. V. Brindley, Temple, presided.

Following reports of work done by the various county auxiliaries represented, the report of the nominating committee, composed of Mesdames S. C. Richardson, Bryan (chairman); A. E. Moon, Temple; and Paul M. Basel, Belton, was heard. Those nominated were unanimously elected to office as follows: Mesdames R. Spencer Wood, Waco, president; J. J. Hopkins, Bryan, vice-president; J. B. Barnett, Marlin, secretary; and A. Ford Wolf, Temple, publicity chairman.

The resolutions committee, composed of Mrs. Wood, chairman, and Mrs. Hopkins, submitted a resolution on the deaths of Mrs. R. R. White, Temple, and Miss Rose Rischar, Cameron. The resolution was adopted, and a free will offering of $20 for the Memorial Fund was sent in memory of the two women.

Mrs. R. D. Moreton, Temple, presented violin selections, and Mrs. T. J. Cloud, Temple, sang. Mrs. L. M. Cochran, Temple, wife of the head of the McCloskey Veterans Hospital, explained the work being done at the hospital by patients and the professional personnel.

Dr. C. C. Cody, Jr., Houston, President of the State Medical Association, spoke on socialized medicine at a luncheon on the roof of the Kyle Hotel. Members of the City Federated Clubs were also present for the luncheon.—Mrs. A. Ford Wolf, Publicity Chairman.

DEATHS*

Dr. William Harrison Moore died at his home in Fort Stockton, Texas, on December 12, 1946, of bronchial cancer.

Dr. Moore, son of J. O. and Amanda (Davis) Moore, was born January 20, 1880, at Lipan, Hood County, Texas. He moved with his family to Jones County, and obtained his early education in Anson. He attended the University of Texas in Austin, and was graduated in 1903 from the University of Texas Medical Department, Galveston. Following internships in Houston and at the Texas-Pacific Hospital in Texarkana, Dr. Moore practiced for short periods in Houston, Dallas, Palestine, Lipan, Stamford, Pecos, and Van Horn prior to moving to Fort Stockton in 1918 during an influenza epidemic. He was in active practice in Fort Stockton until recent months.

Dr. Moore was a member of the Pecos-Jeff Davis-Presidio-Brewster Counties Medical Society, State Medical Association, and American Medical Association. He served as county health officer for Pecos County from the time the office was first established until his death. He was local assistant surgeon for the Southern Pacific, International and Great Northern, and Houston and Texas Central Railways. He was a member of the Catholic Church and past president of the Pecos County Ex-Students Association of the University of Texas.

Survivors include Dr. Moore's wife, the former Miss Virginia Nancy Herren, whom he married at Albany on April 28, 1909; one daughter, Mrs. F. W. Jones, Jr., Brownfield; two sons, Joe Lige Moore and William F. Moore, both of Fort Stockton; two sisters, Mrs. J. H. Rutherford, Stamford, and Mrs. Nib Shaw, Abilene; and three brothers, Dalton Moore, Sweetwater; Mike Moore, Houston; and E. D. Moore, Phoenix, Ariz.

Friends of Dr. Moore are creating a memorial fund in his honor, which will be used for special medical services—special treatment, unusual drugs, or extra care—for Pecos County citizens unable to pay for such services.

Dr. Thomas Moore Dorbandt died December 28, 1946, at his home in San Antonio, Texas.

The son of Christian and Ann Dorbandt, Dr. Dorbandt was born March 17, 1871, at Bertram. He attended the public schools in Bertram, and received his degree of doctor of medicine from old Missouri Medical College, St. Louis, in 1898. Dr. Dorbandt began practice in Lampasas, moved to Galveston in 1908, and then to San Antonio in 1909. He had retired from active practice in 1943.

DR. THOMAS M. DORBANDT

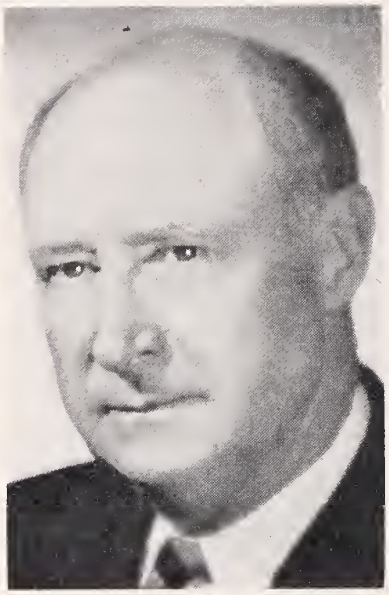
Dr. Dorbandt was throughout his professional career and at the time of his death a member of the State Medical Association and American Medical Association. He had been a member successively of Lampasas County Medical Society, Galveston County Medical Society, and Bexar County Medical Society. He was secretary of the Section on Psychology and Medical Jurisprudence of the State Medical Association in 1908, and was vice-president of the Association in 1935. He had been president of the Bexar County Medical Society, and president and district counselor of the Southern Psychiatric Association. He had been chairman of the San Antonio Board of Health and was a member of the Bexar County Tuberculosis Association. He had been county physician and local surgeon for the Gulf, Colorado, and Santa Fe Railway. He was a member of the Presbyterian Church, the Masonic Order, and the Shrine.

*An obituary ordinarily will not be published more than four months after date of death. Coöperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

Dr. Dorbandt was preceded in death August 30, 1930, by his wife, the former Miss Fannie Robinson, of Austin. Survivors include a son, Dr. M. M. Dorbandt, and two daughters, Mrs. P. D. Dornberger, and Mrs. J. M. Clark, all of San Antonio; two sisters, Mrs. Rose Ellen Buckoff and Mrs. Nannie Phillips, both of Los Angeles, Calif.; and four brothers, Newton Dorbandt, Athens; Seth Dorbandt, Mullins; Robert Dorbandt, Los Angeles, Calif.; and Charles Dorbandt, Rincon, N. Mex.

Dr. George T. Caldwell, Dallas, Texas, died of coronary occlusion in a Dallas hospital January 20, 1947.

The son of William and Agnes (Allison) Caldwell, Dr. Caldwell was born December 18, 1882, at Kennard, Ohio. He attended the local schools and high school at King's Creek. From 1900 to 1902 he taught school. After attending Otterbein University, Westerville, Ohio, for two years, he again taught school, but completed his academic degree at Ohio State University, Columbus, in 1910. He obtained a Life Certificate for Common School Teachers in Ohio at this time. From 1910 to 1912 Dr. Caldwell taught science in the high school at Asheville, N.C. He resumed his studies at Ohio State University and in 1913 received the master of arts degree in chemistry. In 1919 he obtained his doctor of philosophy degree from the University of Chicago and his doctor of medicine degree from Rush Medical College, Chicago, specializing in pathology and physiology. Dr. Caldwell was invited to come to Dallas as the first scientifically trained, full-time faculty member at Baylor University College of Medicine, and from 1919 until the College was moved to Houston in 1943, Dr. Caldwell was active in developing its Department of Pathology. He assisted in establishing Southwestern Medical College in Dallas in 1943, and was professor of pathology there until his death.



DR. GEORGE T. CALDWELL

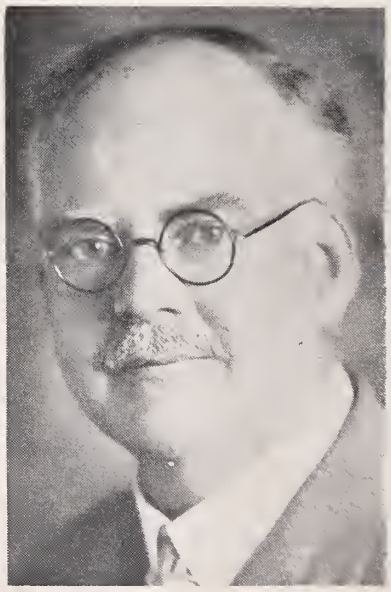
For many years Dr. Caldwell had been a member of the State Medical Association and American Medical Association through Dallas County Medical Society. For a short time he was a member of the Palo Pinto County Medical Society. He was secretary of the Section on Pathology of the State Medical Association in 1928, and of the Section on Clinical Pathology in 1942. He was a member of the American Society of Clinical Pathologists, American Association of Pathologists and Bacteriologists, American Society of Tropical Medicine. American Public Health Association, American College of Pathologists, American Association for the Advancement of Science, American Genetic Society, American Association of University Professors, Southern Medical Association, Texas Society of Pathologists, and Dallas Southern Clinical Society. He was a member of the American Cancer Society, serving on the board for the Texas Division. He was chairman of the Council on Nursing Education of Baylor University School of Nursing. He was a member of Phi Beta Kappa, Alpha Omega Alpha, Sigma Xi, and Lambda Phi Upsilon (chemistry) honorary fraternities. He was a charter member of the Southwestern Medical Foundation Fraternity, Hodin. He was a member of the Society of Friends.

Dr. Caldwell's particular scientific interest was in tumors. In recognition of his knowledge in this field, he was invited to give the Guiterras Lecture before the American Urological Association in 1939 on "Chemical Carcinogenic Agents," being the third American physician to receive this honor. He frequently led the annual tumor seminar of the Texas Society of Pathologists. He had developed an extensive knowledge of botany, and had memorized many poems and quotations which he used aptly.

September 4, 1919, in La Crosse, Wis., Dr. Caldwell married Miss Janet Anderson, who completed her doctor of medicine degree at Baylor University College of Medicine in 1921. Dr. Caldwell is survived by his wife; a daughter, Dr. Marian (Mrs. John T.) Ellis, Dallas; a sister, Mrs. Mary Miller, Kennard, Ohio; two brothers, John Caldwell, Kennard, Ohio, and William Caldwell, Cleveland, Ohio; and one grandchild.

Dr. Gustave Esaias Henschen died January 4, 1947, at his home in Sherman, Texas, of myocarditis and congestive heart disease.

Born August 19, 1875, in Brooklyn, N. Y., Dr. Henschen was the son of William and Hannah (Lilybjorn) Henschen. His father was a Methodist minister, editor of religious papers, and one time professor at Northwestern University, Evanston, Ill. Dr. Henschen was educated in the Evanston public schools; Northwestern University, Evanston, Ill.; and the old Dearborn Medical College, Chicago, from which he was graduated in 1904. He served an internship at Cook County Hospital, Chicago, and then moved to Georgetown, Texas, as physician and surgeon for the Missouri, Kansas and Texas Railway. He was superintendent of the tuberculosis hospital at Llano in 1906, and practiced a year in Denison. Dr. Henschen moved in 1920 to Sherman, where he was a member of the Wilson N. Jones Hospital radiology staff and Neathery Clinic staff until 1937, when he began practicing privately. He had done postgraduate work in roentgenology at Harvard Medical School, Boston; Cook County Hospital, Chicago; and with Count Delebard, Paris, France.



DR. GUSTAVE E. HENSCHEN

Almost continuously throughout his practice in Texas, Dr. Henschen was a member of the State Medical Association and American Medical Association, first through Williamson County Medical Society

and then through Grayson County Medical Society. In 1943 he was elected to honorary membership in the State Medical Association. He was also recently elected to honorary membership in the Texas Radiological Society, an organization to which he had belonged for many years. He had served the county medical societies as president and in 1932 was chairman of the Section on Radiology and Physiotherapy of the State Medical Association. During World War I, Dr. Henschen served in France as a captain in the Army Medical Corps, and during World War II he was cited and given a medal by the United States Government for developing a contrivance to help amputees. He was a member of the Methodist Church and a student of the Bible. He was a member of the Rotary Club and Woodmen of the World.

On April 10, 1907, in Racine, Wis., Dr. Henschen married Miss Ida Annette Anderson, who survives. Also surviving are three sisters, Mrs. Linnea Grant, Evanston, Ill.; Mrs. Earl Ravey, Pasadena, Calif.; and Mrs. Leslie Breeze, Los Angeles, Calif. A son, Eliot Henschen, preceded his father in death by five years to the day.

Dr. Jesse Sharp Hixson died at his home in San Angelo, Texas, on January 22, 1947, of arteriosclerotic heart disease and congestive failure.

Born April 6, 1869, in Oakland County, Mich., Dr. Hixson was the son of Mr. and Mrs. William Hixson. He attended the Pontiac, Mich., high school and a preparatory school in Chicago before receiving his doctor of medicine degree from old Missouri Medical College at St. Louis in 1899. He served an internship at St. John's Hospital, St. Louis, and remained in St. Louis as assistant to Dr. A. V. L. Brokaw until 1906, when he served on the faculty of St. Louis University more than a year as assistant surgeon at St. John's Hospital Clinic. In 1907 he moved to San Angelo because of his wife's health. His practice of surgery without adequate hospital facilities led him to boost the establishment of Saint John's Hospital in San Angelo in 1911, and he subsequently headed the hospital staff. He became active in the promotion of a county hospital and was instrumental in the decision of J. M. and Margaret Shannon to cause their estate to become a trust for the establishment of the Shannon West Texas Memorial Hospital. Terms of the will probated in January, 1932, following Mrs. Shannon's death, provided that Dr. Hixson should be head of the hospital. He became chairman of the board of trustees, and actively supervised and controlled its development. In 1929, Dr. Hixson was associated in the establishment of the San Angelo Medical and Surgical Clinic, but he retired from the clinic in 1937 to devote his time to the Shannon Hospital. A slight stroke seven years ago caused him to relinquish active surgical practice. He suffered his first severe heart attack early in 1946.

DR. J. S. HIXSON

Since coming to Texas Dr. Hixson had been a member of the Tom Green-Eight Counties Medical Society, State Medical Association, and American Medical Association. He was elected to honorary membership in the State Medical Association in 1945. He was made a fellow in the American College of Surgeons in 1917. During World Wars I and II, Dr. Hixson was medical adviser to Selective Service boards. He was a member of the Presbyterian Church, Knights Templar, and Shrine. He was a charter member of the San Angelo Kiwanis Club, but had resigned to join the Rotary Club. He was a member of the school board from 1924 to 1927, when he resigned, and he was active in establishing San Angelo Junior College. Dr. Hixson enjoyed hunting and golf for recreation.

Dr. Hixson's first wife died soon after the couple moved to Texas. In 1913 at San Angelo, he married Miss Mary Cooper, who survives. Also surviving are a son, Dr. William C. Hixson, San Angelo; and two sisters, Mrs. L. A. Hadden, Pontiac, Mich., and Mrs. J. W. Brewster, Oklahoma City.

Dr. Wiley Junior Jinkins, Galveston, Texas, died December 28, 1946, of left ventricular hypertrophy while on a hunting trip near Columbus.

Dr. Jinkins was born December 21, 1887, at Normangee, Texas, the son of J. F. and Nellie (Martin) Jinkins. He attended the schools of Normangee and Morgan, and was graduated from the University of Texas Medical Department, Galveston, in 1911. After serving an internship at St. Mary's Infirmary, Galveston, he began practice in Galveston, where he was active in his profession until 1942, when he retired. Dr. Jinkins, who specialized in surgery, was associated with his brothers, Drs. J. L. and A. J. Jinkins. He was an attache of the medical staff at St. Mary's Infirmary and a visiting staff physician at John Sealy Hospital.

DR. WILEY J. JINKINS

Throughout his professional career Dr. Jinkins was a member of the Galveston County Medical Society, State Medical Association, and American Medical Association. He had served as president of the Galveston County Society and had been an honorary member of the State Association since 1944. He was a member of Phi Beta Pi medical fraternity, American College of Surgeons, Episcopal Church, Masonic Order, Shrine, Eagles, Galveston Artillery Club, Galveston Country Club, Beach Club, Chamber of Commerce, and Rotary Club. At one time he was vice-president of the Medical Building, Inc., of Galveston, and for the past sixteen years a director of the United States National Bank. He was an authority on fine cattle and was director of the American Hereford Association, Texas Here-

ford Association, and president of the Mid-South Hereford Association. He was joint owner with his brother, Dr. J. L. Jinkins, of a large Hereford ranch near Normangee. During World War I, Dr. Jinkins served as a first lieutenant in the Army Medical Corps. He officiated at the birth of the Badgett quadruplets in 1939.

Survivors include Dr. Jinkins' wife, the former Miss Celeste Randolph, whom he married April 14, 1915, in Galveston; a son, Dr. Wiley J. Jinkins, Jr.; and two brothers, Dr. J. L. Jinkins and Dr. A. J. Jinkins, all of Galveston.

Dr. Charles Augustus Gottlieb Langner, Brownsville, Texas, died in the crash of his private airplane near Robstown on January 12, 1947.

Dr. Langner was born December 28, 1900, in Brenham, the oldest son of the late Rev. G. and Elizabeth Langner. He attended the public schools of Brenham and Knippa, and was graduated from Uvalde High School. He attended the University of Texas, Austin, receiving his bachelor of arts degree in 1924. His medical education was secured at Johns Hopkins University School of Medicine, Baltimore, from which he was graduated in 1928. Dr. Langner served an internship at the Boston City Hospital and returned to Johns Hopkins University for a two year postgraduate course at the Wilmer Eye Institute. He practiced a few months at Brenham and at Knippa, and in 1932 began practicing his specialty of ophthalmology at Brownsville. He was called to active duty as a flight surgeon at Kelly Field in August, 1941, having been a member of the Reserve Officers Corps since World War I. Dr. Langner served at Midland, Texas; Chanute Field, Ill.; Camp Carson, Colo.; and nine months in the European Theater. He was separated from active service in February, 1946, with the rank of lieutenant colonel. He retained his commission in the Medical Reserve, but had resumed practice in Brownsville at the time of his death.

DR. G. LANGNER

Dr. Langner was a member of the Cameron-Willacy Counties Medical Society, State Medical Association, and American Medical Association. He was a member of the Lutheran Church, Phi Beta Kappa fraternity, and various aeronautical and civic organizations. He was president of the Brownsville Chapter, Reserve Officers Association.

Dr. Langner married Miss Marie Dallmeyer on May 31, 1937, in Burton. He is survived by his wife and three children, Carl G. Langner, Marie Elizabeth Langner, and Fred William Langner, all of Brownsville; two brothers, W. O. Langner, Knippa, and F. W. Langner, New York; and four sisters, Miss Sophie Langner, Knippa; Mrs. A. G. Wiederaenders, Seguin; Mrs. Wilson V. Hill, Freeport; and Mrs. R. C. Rein, Flint, Mich.

Dr. Bennett Marion Shelton, eye, ear, nose, and throat specialist of Brownwood, Texas, died January 30, 1947, in a local hospital of coronary occlusion.

The son of J. R. and Betty Jane Shelton, Dr. Shelton was born July 22, 1891, at Rockwood, Texas. His bachelor of arts degree was received from Howard Payne College, Brownwood, and his doctor of medicine degree from Baylor University College of Medicine, Dallas, the latter degree being obtained in 1918. He served a one year internship at Baylor Hospital, Dallas, and a one year residency at Cincinnati General Hospital. Dr. Shelton began his practice in Ranger during the oil boom, and moved to Brownwood in 1921. After taking postgraduate work in ophthalmology and otolaryngology in New York, in 1922, Dr. Shelton returned to Brownwood to practice his specialty.

Continuously since 1920 Dr. Shelton was a member of the State Medical Association and American Medical Association, first through Eastland County Medical Society and then through Brown County Medical Society. He was made a fellow of the American College of Surgeons in 1929 and held a life membership in the College. He was past president of the Brown County Medical Society and president at the time of his death of the Medical Arts Hospital. He had been a member of the First Baptist Church of Brownwood for thirty-five years and was president of the church Brotherhood at the time of his death. He was a past president and active member of the Downtown Bible Class and Brownwood Rotary Club. He was a Mason, a former member of the Elks, director of Brown County Water Improvement District, president of the Greenleaf Cemetery Association, and a former member and president of the Brownwood School Board. He was a veteran of World War I and a member of the American Legion.

DR. BEN. M. SHELTON

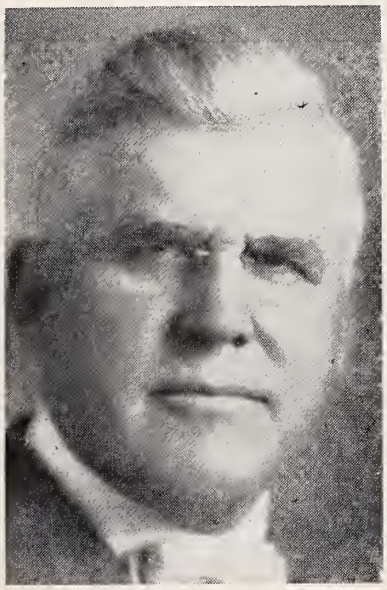
Dr. Shelton married Miss Mary Florence Jones at Salina, Kan., August 26, 1924. Mrs. Shelton died May 7, 1933, and in 1935 at Brady, Dr. Shelton married Miss Lucy Mae Ricks, who survives. Other survivors include three daughters, Mary Elizabeth Shelton, Sylvia Jane Shelton, and Lucy Ann Shelton; two sisters, Mrs. Minnie Floyd and Miss Annie Shelton; and two brothers, Joe R. Shelton and J. Horace Shelton, all of Brownwood.

Dr. Joseph Record died of uremia January 14, 1947, at his home in Beaumont, Texas.

Dr. Record was born August 26, 1876, and received his medical education at the old Fort Worth School of Medicine, being graduated in 1911. He served an internship at the Southern Pacific Hospital, Houston. He practiced first in Corpus Christi and then moved to

Beaumont, where he had continued to practice until the time of his death.

Throughout his professional life Dr. Record was a member of the State Medical Association and American Medical Association, first through Nueces County Medical Society and then through Jefferson County Medical Society. He was on the staffs of Hotel Dieu and St. Therese Hospital, Beaumont. He was vice-president and director of the First Federal Savings and Loan Association of Beaumont, and a member of Phi Chi medical fraternity. During the Spanish-American War, Dr. Record served with the hospital corps in the Philippines. Dr. Record was a leader in the conservation of wildlife and was instrumental in establishing the Texas Wildlife Conservation Society.



DR. JOSEPH RECORD

Surviving Dr. Record is his wife, the former Miss Emily Tabb, whom he married at Houston in 1911.

Dr. Elijah Marion Moseley, Rusk, Texas, died December 31, 1946, of cerebral hemorrhage.

Dr. Moseley, son of E. R. and Rosa A. Moseley, was born December 4, 1873, four miles south of Rusk. He attended Rusk High School, the University of Texas Medical Department, Galveston; and was graduated from old Barnes Medical College, St. Louis, in 1900. He returned to Rusk, and was in practice there until his death. He had been Cherokee County health officer for forty years.

DR. E. M. MOSELEY

Almost continuously throughout his professional career, Dr. Moseley was a member of the Cherokee County Medical Society, Eleventh District Medical Society, State Medical Association, and American Medical Association. During World War I he was a member and later chairman of the Eastern District Board for Selective Service at Tyler, and during World War II he served as a medical examiner for Selective Service at Rusk. He was a member of the Methodist Church.

Surviving Dr. Moseley are two sisters, Mrs. J. W. Bothwell and Mrs. W. E. Bolton, and two brothers, J. H. Moseley and D. M. Moseley, all of Rusk.

Dr. John Metcalf Trible, Houston, Texas, died of coronary occlusion January 20, 1947, in a Houston hospital.

The son of Dr. and Mrs. J. J. Trible, Dr. Trible was born in St. Louis on September 1, 1884. He attended Michigan Military Academy at Orchard Lake, Mich., and was graduated in medicine from St. Louis University in 1907. He began his practice in Dallas, moved to Cuero in 1912, served with the Army from 1917 to 1919, and then located in Houston, where he was actively in practice until his death. He was professor of urology at Baylor University College of Medicine, and was on the visiting staffs of Jefferson Davis, Memorial, St. Joseph's and Methodist Hospitals. He had been chief of staff at Jefferson Davis Hospital.

DR. JOHN M. TRIBLE

Almost continuously throughout his professional career, Dr. Trible was a member of the State Medical Association and American Medical Association. He was a member successively of the Dallas County, DeWitt County, and Harris County Medical Societies, and was president of the Harris County organization in 1943. Dr. Trible was a member of the Southern Medical Association, Post Graduate Medical Assembly of South Texas, and South Central Branch of the American Urological Association. He was a member of the Protestant Episcopal Church, having served several times as senior warden and being a past member of the standing committee of the diocese of Texas. He was a member of Theta Kappa Psi medical fraternity, Lions Club, Houston Turnverein, a director of the Motor League of South Texas (an American Automobile Association affiliate), vice chairman of the medical staff of the local Elks Crippled Children's Clinic, a participant in Community Chest campaigns, a Royal Arch Mason, and member of the Scottish Rite, Shrine, Knights Templar, Knights of Pythias, and American Legion. During World War I Dr. Trible was a captain in the Army Medical Corps, serving on the Mexican border, in France, and in the army of occupation in Germany. In recent years he was a major in the Texas State Guard.

Surviving Dr. Trible are his wife, the former Miss Ottie Belle Bowles, whom he married October 17, 1912, at Dallas; a son, Dr. J. B. Trible, Lt. Comdr., M. C., U.S.N., stationed at the U. S. Naval Hospital, Memphis; his parents, Dr. and Mrs. J. J. Trible,

Biloxi, Miss, and Dallas; and a sister, Mrs. Irene Metcalfe, Dallas.

Dr. Ralph Emerson Utley, Harlingen, Texas, died December 19, 1946, at a local hospital of coronary occlusion.

The son of Theodore L. and Emma A. (McAllister) Utley, Dr. Utley was born at Neenah, Wis. He attended Loyola University, Chicago, and was graduated from old Bennett Medical College, Chicago, in 1914. He practiced for four years in Oak Park, Ill., and then served as a first lieutenant in the Army Medical Corps during World War I. He was associated with a hospital in Montana for a short time after being discharged from military service, and then in 1920 moved to Texas. He practiced first at Donna, Mercedes, and La Feria before locating at Harlingen in 1923. He was actively in practice there until several months before his death.

DR. RALPH E. UTLEY

Since 1920 Dr. Utley had been a member of the State Medical Association and American Medical Association, first through Hidalgo County Medical Society and then through Cameron-Willacy Counties Medical Society. He was also a member of the Third District Medical Society. He was active in the establishment of the Valley Baptist Hospital at Harlingen, and served as its chief of staff in 1944. Dr. Utley was a leader in Boy Scout work in the Valley, serving on the executive committee of the Lower Rio Grande Valley Council and on the finance committee to promote the building of a boys' camp on the bank of the Arroyo Colorado. It was largely through his efforts that a Sea Scout unit was established in Harlingen and a building erected. The ship was named for his son, Kenneth Utley, at his death. Dr. Utley later served as representative of the Valley Council on the National Council of Boy Scouts of America. He was an active member of the Harlingen American Legion post, serving as post commander and as a member of committees to look after the welfare of veterans and their families. He was a member of the Forty and Eight, the Masonic Order, the Kiwanis Club, Chamber of Commerce, the Alumni Association of Loyola University, and the Baptist Church. In 1945 he served on the Harlingen City Commission.

When Dr. Utley first began the practice of medicine in Illinois, he spent most of his spare time for a year in developing the "harmonophone." This machine was the first "juke box," and such features as the record changing device and the push button selector, used on most modern nickelodeons, were the invention of Dr. Utley.

Dr. Utley was first married to Mrs. Bernice Smith. To this union were born two sons, Kenneth Ralph Utley, who died February 14, 1932, and Wallace Alfred Utley, at present a lieutenant commander in the Navy, stationed at Trenton, N. J. On June 20, 1937, at Reynosa, Mexico, Dr. Utley married Miss Dorothy Noma Belden, who survives. He is also survived by three sisters, Mrs. C. C. Yelvington and Mrs. John Jones, both of San Diego, Calif., and Mrs. Arthur E. Ruff, Tenafly, N. J.

Dr. Howard Pleas Wheeler, Georgetown, Texas, was killed January 20, 1947, when his automobile and a truck collided on a highway near Georgetown.

Dr. Wheeler was born February 3, 1909, at New Boston, Texas, the son of Judge and Mrs. Charles A. Wheeler. He secured his academic education at the University of Texas, Austin, being graduated with a bachelor of arts degree in 1929, and his medical education at the University of Texas School of Medicine, Galveston, receiving his doctor of medicine degree in 1932. He served an internship at Hermann Hospital, Houston; a four-month externship at the Southwestern Hospital for the Insane, San Antonio; and practiced about a year in La Pryor before going on active duty in 1934 with the U. S. Army as camp surgeon with the Civilian Conservation Corps in Wyoming, Arizona, and New Mexico. In 1936 he served as an industrial physician in Freeport. He moved to Georgetown in December 1936, and was in practice there until his death, with the exception of a period in which he was in military service. He was commissoned to the Medical Corps of the Army in August, 1942. After receiving training as a flight surgeon, Dr. Wheeler went overseas in January, 1944, and served with the Ninth Air Force in France, England, and Belgium, until his discharge in October, 1945, as a captain.

During his years of practice Dr. Wheeler was a member of the State Medical Association and American Medical Association, first through Medina-Uvalde-Maverick-Val Verde-Edwards-Real-Kinney-Terrell-Zavala Counties Medical Society and then through Williamson County Medical Society. He was president of the Williamson County Society in 1941. He was an associate member of the Dallas Southern Clinical Society, and a member of Phi Chi medical fraternity, the Christian Church, Odd Fellows, American Legion, and Veterans of Foreign Wars.

DR. HOWARD P. WHEELER

Surviving are Dr. Wheeler's wife, the former Miss Mary Josephine Davidson, whom he married August 17, 1939, in Fort Worth; four children, Sarah Jo, Paula, Dorothy Ann, and Howard Pleas, Jr., all of Georgetown; four brothers, Dr. Morris Wheeler, Joe W. Wheeler, and J. P. Wheeler, Austin; and Charles A. Wheeler, Jr., Temple; and his parents, Judge and Mrs. Charles A. Wheeler, Sr., Austin.

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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION AND PUBLIC HEALTH IN TEXAS

The Dallas Annual Session Program, May 5, 6, 7 and 8, 1947, is published in all its fullness and glory in this number of the JOURNAL (page 702). It is hoped that our readers will look the program over. It is both interesting and informative. Beyond any doubt, the programs of the General Meetings and the Scientific Sections are most excellent, as good as any we have ever had, and the setup for the whole meeting is most convenient, indeed. The entertainment features are attractive, some think entirely too attractive, and the whole story is most persuasive. Perhaps we should suggest here that those who expect to attend the meeting do something about hotel reservations forthwith and immediately, if they have not already given that important matter their attention. Dr. Jack G. Kerr, Medical Arts Building, Dallas, is Chairman of the Hotels Committee, to whom appeals should be made in the instance the hotel of choice of any member cannot take care of him.

The Medical Arts Building, Dallas

This is the second full-dress meeting the Association has held since the beginning of the war. Our experience at Galveston last year helped a lot, and while the Central Office and the management have been working at great disadvantage, it is thought that arrangements for this meeting are sufficiently well under way to guarantee success in every particular.

The programs of our annual sessions are most confusing, indeed, at first glance. There is a good deal of them, and they are scattered about over several pages. However, a little consistent effort will make them crystal clear and all that programs should be. There is no way to make the layout any simpler than our Council on Scientific Work has made it.

It is recommended that in a study of the program, the schematic drawing published with the program be used as a guide. For instance, it will be noticed that the activities of each day are tabulated under day and date concerned, not in detail, but definitely tabulated. The program sets out the details of each event thus tabulated, including programs for the General Meetings, the Combined Sections Meetings, the Clinical Luncheons, and the Scientific Sections. The programs of the special societies which meet with us are given, as well as the programs for the House of Delegates and the Memorial Services. The entertainment features and the alumni and fraternity banquets are spotted. It is a simple matter to find what is wanted, and then look up the details in

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the printed program. For instance, on Monday, May 5, the several special societies, referred to above as always meeting with the State Medical Association, although they have no connection except common interest, will meet, and the program of each of them is listed along with the programs of our own meetings.

On Tuesday, May 6, which is the day upon which the annual session officially opens, the schematic drawing shows that Registration will begin at 8:00 a. m. The Opening Exercises, at which our President will deliver his annual address, will be called to order at 9:00 a. m., and the first General Meeting of the session will begin at 10:15 a. m. It will be noted that the Scientific Sections all begin their meetings in the afternoon of that day. The alumni and special group banquets will be held on the evening of that day, and the House of Delegates will meet at 7:00 p. m. Incidentally, this is the first time the House of Delegates has been scheduled to meet at any such time. It is sandwiched between meetings of the Scientific Sections and the President's Reception and Ball, which will be held in the evening on that day, beginning at 9:15. Incidentally, it may be well to say that the House of Delegates determines it own meeting time. The President can call a meeting ahead of time, which he does habitually. The first meeting will be held on Monday, and up into the night if necessary. The only other time the House of Delegates must of necessity meet will be Thursday morning, May 8, at which time officers are due to be elected. Any meetings in between will be set by the House itself. However, the management has made the suggestion that it might well also meet Tuesday afternoon between times, and Wednesday at 8:00 a. m. All of this rearrangement has been made necessary by the program the Dallas County Medical Society has provided for the entertainment of our members on Wednesday evening. It was felt that the House of Delegates could not cope with the very fine entertainment sure to be extended by the Dallas County Society.

It is generally thought that the House of Delegates cannot meet at the same time the Scientific Sections are in session, except for the Thursday morning meeting, but such is not the case. The matter is expressed in the By-Laws of the State Medical Association, in the following language referring to the House of Delegates: "the which shall meet from time to time through the annual session as may be necessary, avoiding as far as possible conflicts with the meetings of the Scientific Sections, and with other activities of the Association."

On Wednesday of the meeting, the House of Delegates is scheduled to hold forth until noon. The Section meetings will also be held until the noon hour. The Clinical Luncheons, three of them, Medicine and Pediatrics; Surgery, Obstetrics, and Gynecology; and Eye, Ear, Nose, and Throat, will take place at noon. A General Meeting will be held in the afternoon from 3:00 to 4:30, and the Memorial Exercises will follow immediately and in the same room.

Fraternity banquets will be held in the evening of that day, and the Dallas County Medical Society will entertain, beginning at 6:30 p. m.

On Thursday, the House of Delegates will hold presumably its final meeting, beginning at 8:00 a. m. The last General Meeting will be held that day, beginning at 9:30 a. m. A Clinical Luncheon, combining all sections, will begin at noon, and the Combined Sections Meeting will be held in the afternoon, beginning at 2 o'clock.

As we have said, each of these events is dealt with at length and in detail in the program, and every effort has been made to set out the information so that it may be readily accessible.

Full information of the entire meeting will be found under "Announcements" (page 702). It will be noted here that the Registration Office and Information Bureau will be on the lobby floor of Hotel Adolphus, except for the registration of the Woman's Auxiliary, which will be held at the Baker Hotel, across the street. Places for the meetings of the Scientific Sections, the House of Delegates, the Board of Councilors, and for all important events are given concisely under these announcements.

A list of Officers, Councils, and Committees of the Association, and the Local Committees, will also be found in the printed program, as is the agenda for the meetings of the House of Delegates, all of which will be held, as stated, at Hotel Adolphus.

As already hinted, there will be more than the usual amount of entertainment. The Dallas County Medical Society will entertain visitors at a Buffet Supper and Dance, on Wednesday, beginning at 6:30 p. m., at the Plantation, an entertainment spot at 6400 Harry Hines Boulevard.

The President's Reception and Ball will be held Tuesday at the Baker Hotel, beginning at 9:15 p. m. A perfectly good orchestra has been employed for the occasion, and there will be plenty of punch.

Alumni and special group banquets are listed for Tuesday, at 6:00 p. m., and frater-

nity banquets for Wednesday at 6:30 p. m.

There will be golf, of course, and a skeet and trap shoot. They are both annual events and will be well organized. The Stewart Adams Trophy, a silver cup donated by the Bexar County Medical Society, will go to the high over-all marksman in the trap shoot. The person who wins the cup the third time in successive years will retain it permanently.

The Woman's Auxiliary will hold all of its meetings at the Baker Hotel. The women's program will be reprinted independently, on their own, but it is published in this JOURNAL on page 725. As it has been made to accord with the program of the State Medical Association, there will not be any conflicts of material interest to the members of either organization.

The Memorial Services will be held in the Ballroom of the Hotel Adolphus beginning at 4:45 p. m., Wednesday, immediately following adjournment of the General Meeting held on the afternoon of that day, and in the same room. As usual, these will be joint services of the State Association and of the Woman's Auxiliary.

Of great importance and interest will be the Clinical Luncheons. There will be three of these luncheons on Wednesday, as already stated, one for Medicine and Pediatrics, another for Surgery, Obstetrics, and Gynecology, and another for Eye, Ear, Nose, and Throat. A combined luncheon of all of the sections will be held on Thursday. As is generally well known to our readers, the distinguished guests of the several scientific sections will sit at the speakers' table at these luncheons, and will speak upon any questions propounded by their audiences. It is expected that these questions will be made out and handed to the presiding officer of the luncheon at the time of assembly, or to section officers prior to the luncheons. Each question will be addressed to a particular speaker, and answers will be concise and of the rapid fire order. An important consideration this year will be the requirement of the Council on Scientific Work that tickets for the Clinical Luncheons be purchased at the time of registration, and that admission to the luncheons will be only by ticket. The purchase price of any tickets will be refunded upon request up until 6:00 p. m. of the day prior to the luncheon. They cannot be refunded after that time. No tickets will be sold after 10:30 a. m. on the day of the luncheon. The reason for this restriction is that unless something of the sort is required there is no way to estimate the number of guests to be served at any given luncheon. In days gone by there was much more leeway in the matter. For one thing, whereas the luncheons formerly cost 75 cents or $1, they now cost $1.75 per plate. That is too much financial responsibility for the Association to assume on a long chance. The deficit in connection with the luncheons at the Galveston meeting was considerable, and nothing could be done to prevent it. It is hoped that the new rule will save money, and facilitate the management of the Clinical Luncheons.

Of special note this year will be the revival of our heretofore very fine scientific and technical exhibits. The scientific display at Galveston was curtailed somewhat by lack of material so shortly following the war. The technical exhibits at that meeting were restricted a bit because of lack of room. These factors still enter the case, but at the same time there will be unusually fine exhibits of both the scientific and technical sort. They are listed in the program, together with the names of those in charge.

Again we would suggest that all who can do so attend the Dallas meeting, and that those who expect to attend and have not done so, take care of hotel reservations right away.

Not Too Late to Pay Dues. On April 1 of this year, as we go to press, there are exactly 4,499 members of the State Medical Association of Texas. That is some sort of a record. At the same date last year, the membership of the Association was 3,352. We are, therefore, exactly 1,147 members ahead of last year. The total membership for 1946 was 5,044. That in itself is something of a record. We are not sure whether the change in our fiscal year has made the difference. We are rather inclined to believe our members are more acutely aware of the importance and value of membership and, not to be forgotten, they are probably "in funds." Because of the shortage of physicians throughout the country and the fact that our people have more money to spend than they have had in a long time, doctors are probably coming nearer to getting what is due them.

Our purpose in discussing the subject at this time is to impress upon our readers the fact that it is never too late to pay dues. The By-Laws permit the payment of dues throughout the calendar year, thereby perpetuating membership. After the expiration of the calendar year, it will be different. Membership ceases January 1. It can be renewed without formality any time during the year simply by paying dues, but such renewed membership, while for the year designated, dates from the day payment is actually made, not from January 1, as is the

case with those whose names appear on the annual reports of their county medical societies.

It must be remembered, however, that the State Secretary can accept dues only from county society secretaries, or in the inability of the county society secretary to act, from the president. One of these officials can give a member a written permit to pay his dues at the annual session. If that is done, and the member pays his dues at the time of registration, and his secretary subsequently sends his dues in, the duplicate payment will be refunded promptly. Thus the member himself will be out nothing, except the use of the money involved for a few days. It seems difficult for our members to realize that the State Secretary must be governed by the By-Laws, regardless, in this as in every other respect. The fact that a member has paid his dues to his county society secretary does not mean that the State Secretary can permit him to register as a member. The State Secretary must have the money in his possession, or must get it, and he cannot take it from the member himself except said member has written permission of the county secretary or president to make the payment. We go to considerable length in explaining the situation for the reason that such situations arise frequently during each annual session, to the embarrassment of all concerned.

Therefore, and this is what we started out to say, any member can pay dues at the time he registers at the annual session, provided he brings with him written permission from his county society secretary to do so.

Narcotics Laws of the Federal Government are inadvertently being violated by some physicians, primarily those who practice in states bordering on Mexico or Canada, and the narcotics authorities have requested publication of the following statement so that Texas physicians will be properly informed:

"Under the provisions of the Narcotic Drugs Import and Export Act, it is unlawful for a physician to carry narcotic drugs in his medical bag back and forth between the United States and Mexico and between the United States and Canada. Narcotic drugs found in the possession of a physician upon returning to the United States are seized and forfeited. Because of lack of knowledge of the law, many physicians are caused embarrassment and inconvenience when travelling between this country and Mexico or Canada."

Members of the State Medical Association will certainly wish to conform to the provision of the narcotics regulations called to their attention here. If there is any doubt concerning the legality of other activities in connection with the distribution and use of narcotics, the federal authorities will be glad to explain the laws which apply.

Radio Recognition of Texas Medicine will be given Saturday, April 26, on the American Medical Association-National Broadcasting Company series "Doctors—Then and Now." Most N. B. C. stations will carry the program. The original broadcast will be at 3 p. m., Central Standard Time; some stations will use a rebroadcast at a different hour.

It is appropriate that the participation of Texas in the centennial celebration of the founding of the American Medical Association should feature a dramatization of the life of Dr. Anson Jones, the physician who served as the last president of the Texas republic and, in 1845, less than two years before the American Medical Association was born, presided over the rebirth of Texas as the twenty-eighth state in the United States. It is also fitting that Texas be recognized on a date so near to the anniversary of the Battle of San Jacinto; Dr. Jones was surgeon to the Second Regiment of the Texas forces in the Battle of San Jacinto, on April 21, 1836, which gave Texas its independence from Mexico.

Sharing honors in the broadcast, will be Dr. Elliott Mendenhall, Dallas. Dr. Mendenhall, associate professor of clinical medicine at Southwestern Medical College, chairman of the Section on Public Health of the State Medical Association, and president of the Dallas Southern Clinical Society, will speak from Dallas. He will touch on the growth of the State Medical Association of Texas, the contributions of the medical colleges, the centers of research which are receiving acclaim everywhere, and the great hospitals of the state.

The American Medical Association, with the cooperation of the National Broadcasting Company, initiated its series of centennial programs last December. Each Saturday afternoon some region of the United States has been honored. A dramatization of the life of a pioneer physician of the region and a short resume of current medical activities, given by a physician of the area, have been included in each broadcast. By the time the series is concluded, progress in medicine during the past one hundred years, and its present status throughout the nation, will have been reported.

Members of the State Medical Association of Texas and its Auxiliary will be proud to listen to the April 26 broadcast of "Doctors—Then and Now," and they will certainly want to encourage their friends to listen. The

medical profession of Texas is fortunate in having this opportunity to tell its neighbors within the state and throughout the nation, of the contributions which medicine has made to the Southwest. For the Association, we take this means of expressing appreciation to the American Medical Association, particularly the Bureau of Health Education and its director, Dr. W. W. Bauer, and to the National Broadcasting Company, for making this program possible. Thanks are also extended to Dr. P. I. Nixon, San Antonio, and Dr. Herbert Gambrell, Dallas, whose research in Texas history has been of invaluable assistance in the preparation of the script.

Volume XLII of the Journal is complete with this issue. As usual, the editors have paused to consider the past year's activities before going on to a new volume.

The JOURNAL for 1946-1947 has been larger in almost every respect than the volume for the preceding year, despite the difficulty of securing paper stock. Total pages for the year number 1,652, while volume XLI carried only 1,530 pages. The subscription list has steadily lengthened; more copies of each number of the JOURNAL are being printed and distributed than ever before in the history of the publication.

Advertisers have continued to request space and, incidentally, have increased their use of color. Advertising pages in the current volume have totaled 896, as compared with 830 pages in volume XLI. Additional advertising could have been secured without solicitation, but the shortage of paper has made it impossible to accept more advertising without unbalancing the JOURNAL. As a matter of fact, a rough survey of the volume indicates that advertising for the year led reading by 140 pages, as reading pages total 756. At that, there were 56 more pages of reading matter in volume XLII than in volume XLI.

A break-down of reading material included in the current volume reveals that there were 89 pages devoted to editorials, 315 to original articles, and 336 to miscellaneous. Figures for the preceding volume are 81 pages of editorials, 332 of original articles, and 287 of miscellaneous. Approximately the same number of original articles were published in each volume (91 in the current volume; 88 in the preceding volume). Contributions were scarce and difficult to obtain during 1945-1946; but the resumption of meetings by various organizations, including the State Medical Association, and the return to research by physicians who had been busy with military duties or civilian care during the war have resulted during the past year in a flood of original articles with which it has been difficult to cope. It has been necessary to delay publication of many worthy articles, and in more than one instance to refuse perfectly good contributions outright because of lack of space.

Proportionately more space has been devoted to the library department of the JOURNAL in recent months. Merely reporting the growth of facilities and the increased services of the Library has enlarged the department. In addition, the JOURNAL has made an effort to assist the Library in its program of expansion by giving suitable publicity to its needs and appropriate recognition of the acquisition of both books and motion picture films, most of which have been made available to the Library without cost. Items pertaining to the Library and to literature or motion pictures have been focused in one section of the JOURNAL so that now readers will find all such material on succeeding pages of each issue.

It would be inappropriate not to make of record here the fact that volume XLII is the last volume in which the name of Dr. R. B. Anderson, Jr., will be carried at the masthead as Assistant Editor. Dr. Anderson's death in January brought to a close almost twenty years of active participation in the policy making of the TEXAS STATE JOURNAL OF MEDICINE, and in the routine of writing, editing, and checking its contents.

Those readers who keep permanent files of the JOURNAL will be interested to know that red morocco binding with gilt lettering, uniform with the bindings contracted for each year for many years past, may again be secured at the price charged by the bindery. Back numbers of the JOURNAL will be furnished without additional charge to the extent possible, but reserve supplies are, of course, limited. Details as to price of binding and availability of back numbers will be supplied upon request.

The Editors wish to thank readers of the JOURNAL for their interest, and its contributors for their assistance during the past twelve months. The official publication of any society must depend for its success on the cooperation of members of the organization. We have been aware of the cooperative attitude of members of the State Medical Association of Texas and their friends during the past year; we believe volume XLII of the JOURNAL reflects that helpful spirit.

CURRENT EDITORIAL COMMENT*

National Conference on Rural Health.—The Second National Conference on Rural Health was held in Chicago, February 7-8, 1947. The Conference was composed of leaders of the various farm groups, educators, public health workers, and the A. M. A. Committee on Rural Medical Service. Our area is composed of Texas, Oklahoma, and Kansas. Each state was represented at the meeting, and an area conference was held on the second day.

On the first day, at the morning meeting, there were general addresses by members of the farm groups and members of the A. M. A. committees. The afternoon was taken up in sectional meetings where there were panel discussions of the following problems: (1) hospital facilities and health centers in rural areas, (2) methods of bringing and holding physicians and dentists in rural areas, (3) voluntary prepayment plans, (4) nursing needs of rural communities, (5) the health council as an agency for promoting rural health, and (6) medical care for low income groups. Following the panel discussions, each sectional chairman and his committee met in the evening and drew up recommendations, which were read the following morning. The entire assembly was addressed at a luncheon on the second day by Dr. Harrison H. Shoulders, Nashville, Tenn., President of the A. M. A., on the subject "Maladjustment in Medical Service."

Since this conference was composed of various groups, it could function only as an advisory body. Its decisions could only take the form of resolutions, which could then be activated by community and state organizations.

Looking at the meeting from a medical standpoint, I received the following impressions:

1. The A. M. A. is making an earnest effort to meet the needs for more medical service in rural areas, insisting at the same time on the maintenance of efficiency and ethical standards.

2. The various farm groups have the same purpose, but they differ radically upon the methods proposed for the solution of the problem. The Farm Bureau is moderately conservative, sound in its thinking, insisting on free enterprise and community initiative, and the support of a program on community and state levels rather than on a national level. Voluntary prepayment insurance plans are fostered, with state aid supplemented by federal grants when necessary, but compulsory health insurance is vigorously opposed. This group is realistic, conservative, and has a program of long range planning for the betterment of rural health throughout the entire nation. The National Grange is more to the left in its thinking. It favors the administration of medical service to farm areas on a cooperative basis, and insists that the consumer should dictate the administration of this service. If medical service cannot be rendered on such a basis, the Grange favors government control. The Grange is seconded in its efforts by the National Association of Consumer Cooperatives. Furthest to the left, and consequently the most radical in their recommendations, are the members of the Farmers Union, forthrightly predicting that voluntary prepayment plans cannot meet the problem in rural areas and will fail, and insisting on a program of compulsory health insurance, that is, government administration of medical service.

From these facts, it may be seen that the farm groups present no united front in attacking the problem of rural health, but are widely divergent, ranging from conservative free enterprise advocates to radical leftist groups insisting on government medicine. Caught between these is the medical profession, somewhat bewildered in trying to satisfy the demands of various groups. Whether the divergent ideas of the various farm groups can be amalgamated into a unified plan, or whether they are irreconcilable, remains to be seen. The more radical a group is, the more its tenets seem to become a religion and the more uncompromising the group is.

The demand which is most alarming, and which is an echo of the Cooperatives Convention in Two Harbors, Minn., last summer, is that the Cooperatives should be in control of the entire field of medical service. This would mean that the doctor would be under the direction of the cooperative agency and only a cog in the machine. My conviction, at the present time, is that these views are too widely divergent, and the champions of each too uncompromising to permit the formation of an over-all acceptable plan. We may be compelled to let it be thrashed out on a local level or, possibly, on a state level, because it seems that certain sections of the country might be happy with one plan, whereas another section would prefer something entirely different. Right now, it behooves the medical profession to be on the alert, to assert its rights, to stress its importance in any plan,

*This department of the JOURNAL presents editorial comments on current items pertaining to the science, art and practice of medicine, contributed by members of the State Medical Association and scientists closely associated with the medical profession of Texas. Invitation is hereby extended to any member of the State Medical Association of Texas to submit such discussions for this department. The discussions should not be more than 500 words in length.

and to refuse to be dictated to or pushed around.

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INDICATIONS FOR PULMONARY RESECTION

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Interest in diseases of the thorax has been increasing rapidly in recent years. Two factors have contributed largely to this development. First, progress in thoracic surgery has made the thorax as accessible to surgical invasion as any other part of the body, and many thoracic lesions for which there had been no satisfactory treatment have become amenable to surgical treatment. Second, roentgenographic surveys of large numbers of our population by the Army, Navy, and various public health agencies have disclosed a surprising number of unsuspected thoracic lesions of various types which have demanded the attention of physicians everywhere. The surveys that have been carried out offer convincing evidence that the making of a roentgenogram of the thorax should be a part of every thorough physical examination. It is at least as important as a routine examination of the blood and urine, and will produce fully as many positive results. Physical examination of the thorax by inspection, percussion, and auscultation, no matter how skilled the examiner, cannot provide accurate information regarding whatever condition may be present in the thorax. Successful treatment of most thoracic diseases requires early diagnosis. Means of diagnosing thoracic lesions are available. Physicians everywhere must accept their responsibility for the diagnosis of lesions involving the thorax and its contents, so that appropriate treatment can be carried out at an opportune time. I shall limit my discussion to those lesions for which pulmonary resection may be indicated.

CARCINOMA OF THE LUNG

The lung is second only to the stomach as a site for the frequent development of cancer in the human body. It is worthy of note that, whereas there has been no significant statistical increase in the incidence of carcinoma in other parts of the body, there has been a very great increase in the incidence of carcinoma of the lung, and that, whereas in 1900 the lung was the tenth most common site of carcinoma, it is now second.

Read before a General Meeting, State Medical Association of Texas, Galveston, May 9, 1946.

It is now estimated that at least 10 per cent of all deaths caused by carcinoma are the result of carcinoma of the lung. Carcinoma of the lung may occur at any age, but it usually occurs in persons between 40 and 65 years of age. In 88 per cent of a series of 448 cases of proved carcinoma of the lung reviewed recently, the patients were more than 40 years of age. Men are afflicted with carcinoma of the lung about four times as frequently as women.

Carcinoma of the lung presents no pathognomonic symptom complex. Actually, it can simulate many other pulmonary conditions. However, in nearly every case reviewed, the history indicated the presence of disease very early in the course of the illness. It is unfortunately noticeable in a review of the cases that an average of more than eight months elapsed between the date of onset of symptoms suggesting thoracic disease and the date of accurate diagnosis of the condition. Cough was the most common, and usually was the early, manifestation of carcinoma of the lung in the cases comprising this study. Hemoptysis was noted in 53 per cent of all cases. Wheezing, dyspnea, and pain in the thorax was noted frequently. Seventy per cent of the patients had lost more than 10 pounds (4.5 kg.). A history of prolonged chest colds and recurrent attacks of pneumonia frequently was given. Thus, any patient who has any symptoms referable to the thorax that cannot be definitely accounted for on some other basis should be suspected of having a carcinoma of the lung and should be studied accordingly.

Carcinoma of the lung may produce bizarre roentgenographic signs that defy accurate interpretation. However, in the group of 448 persons with proved carcinoma observed at the clinic, correct diagnosis was made on roentgenographic evidence alone in 73 per cent of the cases. The roentgenographic observations may be divided into three main groups: (1) the group in which the tumor casts a distinct shadow, constituting the predominant roentgenographic sign; (2) the group in which secondary manifestations, such as atelectasis, comprise the outstanding observation; and (3) the group in which complicating factors, such as bronchiectasis, pulmonary abscess, and pleural effusion, are the predominant features and often completely overshadow the underlying tumor.

Bronchoscopy is an invaluable aid and should be carried out in every case in which the possibility of carcinoma of the lung is suggested. In 70 to 75 per cent of cases of carcinoma of the lung, the lesion occurs in bronchi that are accessible to bronchoscopic examination and biopsy. Bronchoscopy, in

addition to furnishing accurate information as to the pathologic nature of these lesions, is valuable in determining the site of the lesion, and it provides important information regarding operability of the lesion.

In 25 to 30 per cent of cases of pulmonary carcinoma, it is impossible to obtain specimens for pathologic examination. In those cases a diagnosis must be made on the basis of the clinical and roentgenologic observations. I believe very strongly that no patient should be denied the benefit of thoracic exploration if the history, clinical examination, and roentgenologic examination suggest the presence of carcinoma of the lung. In such cases, exploratory thoracotomy is a justifiable procedure, since there is no other means of establishing an early diagnosis of the lesion and carrying out treatment at an opportune time. There is no more risk involved in exploratory thoracotomy than there is in exploratory laparotomy, and there should be no hesitation to recommend an exploratory operation in cases of suspected carcinoma of the lung.

Our experience has shown conclusively that radiation therapy is not effective for carcinoma of the lung. Radical resection of the lung and the regional lymph nodes is the only proper treatment. Pneumonectomy for carcinoma of the lung is based on the same principle as that of surgical treatment of carcinoma in other sites, that is, excision of the lesion and the involved regional lymph nodes. Obviously, many special problems attend the removal of an organ as vital as the human lung. However, these problems have been overcome to a great extent.

Since carcinoma of the lung occurs, for the most part, in persons who are middle aged and older, careful evaluation of their general physical condition must be made before operation is advised. The patient should be in good general condition; the heart and opposite lung should be essentially normal. There should be roentgenographic or bronchoscopic evidence of a pulmonary lesion and every attempt should be made to rule out other pulmonary conditions, such as abscess, bronchiectasis, and tuberculosis. Age in itself should not necessarily contraindicate surgical intervention. It has been apparent to surgeons interested in surgery on persons of advanced years that even an extensive operation of this type can be carried out for elderly persons without excessive risk.

Not enough patients who have undergone pneumonectomy have been followed long enough to permit an accurate evaluation of the prognosis, but evidence thus far indicates that prognosis is at least as favorable as that after resection for carcinoma of the stomach.

Carcinoma of the lung is one of the commonest carcinomas in the body, and apparently it is increasing in frequency. Surgical resection of the lung and the regional lymph nodes is the only effective treatment. Earlier diagnosis of these lesions of the lung will contribute more to the effectiveness of the operation than any other factor. Exploratory thoracotomy is indicated in all cases of proved carcinoma of the lung in which there is no positive evidence of inoperability. Bloody pleural effusion, a fixed vocal cord, or a paralyzed diaphragm are evidences of inoperability. It should be remembered that carcinoma of the lung not infrequently metastasizes to the lymph nodes, liver, kidney, brain, and the other lung; hence, a thorough search for possible metastasis always should be made. I would emphasize again that exploratory thoracotomy is a justifiable procedure in those cases of indeterminate thoracic lesions in which the history and examination suggest that the lesion may be inoperable, even though it cannot be proved before operation.

BRONCHIAL ADENOMAS

There is a difference of opinion among pathologists as to whether bronchial adenomas are benign or malignant tumors. Whether they are benign or malignant, they are very different from carcinoma of the lung. Whereas carcinoma of the lung occurs predominantly in men, 60 to 80 per cent of bronchial adenomas occur in women. Most adenomas occur in persons less than 40 years of age, whereas only 10 to 15 per cent of carcinomas occur in persons of this age group. Bronchial adenomas always occur in the main stem bronchi and usually are accessible to bronchoscopic examination, whereas 25 to 30 per cent of carcinomas are located in the portion of the lung beyond bronchoscopic reach. The difference in prognosis between carcinoma of the lung and bronchial adenomas is interesting, as indicated by figures from the Massachusetts General Hospital. Of a series of 155 patients who were found to have bronchial carcinoma, only 3 per cent were alive three to five years later. By contrast, of a series of 17 patients who were found to have bronchial adenoma, 88 per cent were alive after the same period. In this respect, it is unfortunate that bronchial adenomas constitute only about 10 per cent of pulmonary tumors.

Symptoms of bronchial adenoma are similar to those of carcinoma of the lung, except that they occur in younger persons and usually are of longer duration. Cough,

hemoptysis, and even severe hemorrhage are characteristic. Recurrent attacks of pneumonia are common. Roentgenologically, the characteristic observation is atelectasis of the lobe of the lung distal to the bronchial tumor.

There is some difference of opinion about the proper treatment of bronchial adenomas. Since these lesions are accessible to bronchoscopic treatment and since they grow slowly and are relatively benign, some have favored bronchoscopic removal of the tumor rather than the more radical pulmonary resection. I believe, however, that bronchoscopic treatment of these tumors should be used only when the general condition of the patient will not permit pulmonary resection. My reasons are as follows: (1) there usually is extensive pulmonary damage, particularly pulmonary suppurative disease distal to the lesion; (2) it is impossible to remove the entire lesion bronchoscopically, since most of the tumor lies outside the bronchus; (3) if bronchoscopic removal is employed, repeated bronchoscopy at frequent intervals for the rest of the patient's life will be necessary; (4) the tumors are very vascular, and severe hemorrhage may be encountered at the time of bronchoscopic removal; (5) even though these tumors grow slowly and are relatively benign, authentic instances of metastasis have been reported; and (6) the risk of surgical resection is not great, the fatality rate being only about 5 per cent.

Although I am convinced that pulmonary resection is preferable to bronchoscopic removal of these tumors, bronchoscopy does play a very important part in management of them. Bronchoscopy allows partial removal of the lesion that is obstructing the bronchus, and thus relieves atelectasis and permits drainage of the suppurative process distal to the lesion. In that way the patient can be brought into a better condition for surgical resection. Bronchoscopy also provides a specimen of the lesion for histopathologic examination, so that the exact nature of the tumor is known before surgical resection, and it gives information regarding the location of the lesion, which is important. Because, in most instances, lobectomy is adequate, it is not necessary to do a more radical resection unless the location of the lesion makes pneumonectomy necessary.

PULMONARY SUPPURATIVE DISEASE

Pulmonary suppurative disease provides one of the largest fields for which pulmonary resection may be indicated. These diseases include bronchiectasis, and abscesses and cysts of the lung. In general, these diseases have been badly neglected, and it is time that more attention be given to patients who have a chronic, productive cough that is not caused by tuberculosis. The seriousness of these diseases must be appreciated so that successful treatment can be carried out at the optimal time, rather than after serious complications have developed.

Bronchiectasis is the most common of the aforementioned diseases. It is essentially a disease of children and young adults. In most cases it is difficult to determine accurately the age of the patient at the onset or the duration of the disease because the course is so marked by remissions and exacerbations. It is characterized by the production of purulent sputum, the quantity of which varies considerably. The sputum often has a foul odor. Hemoptysis is very common; it has occurred in 42 per cent of cases in our experience. Hemoptysis may be very severe and hemorrhage requiring the transfusion of blood occurs occasionally. In table 1 are listed the symptoms noted in a series of 471 cases which we have reviewed. Bronchiectatic patients have little resistance to respiratory infections and their course usually is prolonged. It has been only since 1922, when radiopaque oil (lipiodol) was introduced, that a method has been available for diagnosing the location and extent of bronchiectasis in the living patient. In table 2 are indicated the situation and extent of bronchiectasis in 202 of 471 cases.

TABLE 1.—*Signs and Symptoms of Bronchiectasis; 471 Cases.*

	Cases	Per Cent
Cough	463	98
Hemoptysis	198	42
Fever	89	19
Loss of weight	89	19
Dyspnea	36	8
Pain in thorax	12	3
Clubbing of nails	70	15

TABLE 2.—*Situation and Extent of Bronchiectasis; 202 of 471 Cases.*

		Cases	Per Cent of 202
Right lung	Upper lobe	4	
	Middle lobe	3	
	Lower lobe	39	19
	Entire lung	4	
Left Lung	Upper lobe	2	
	Lower lobe	71	35
	Entire lung	8	
Both lower lobes		39	19
Extensive, bilateral		15	
Right lower and middle lobes		2	
Left lower lobe and lingula		10	
Miscellaneous		5	
Total		202	

The seriousness of bronchiectasis has been appreciated only fairly recently because not a large enough number of patients with accurately diagnosed bronchiectasis have been followed long enough to permit an evaluation of the prognosis of this disease. It is now

known that the pathologic changes of bronchiectasis are irreversible, so that once bronchiectasis has developed it usually is a progressive disease that results fatally. Evidence has been presented by a number of investigators indicating that the majority of persons with bronchiectasis succumb to some form of respiratory illness or complication before or during the fourth or fifth decade of life. It is also important to point out that from a social and economic standpoint bronchiectasis is a serious problem. The patients are chronically ill and are social outcasts because of the objectionable character of their disease. Only a few are able to support themselves.

The only effective treatment for bronchiectasis now available is surgical resection of the involved pulmonary lobe or lobes. A variety of more conservative procedures have been attempted. In general, it can be said that any patient between the ages of 4 and 40 years, and occasionally older, who has bronchiectasis that is reasonably localized and who presents no serious general contraindication should be considered as a candidate for pulmonary resection. The most favorable cases are those in which a single lobe is involved, but it is possible to consider pneumonectomy when the disease involves one entire lung or, in some selected cases, to consider bilateral lobectomy.

Since in most cases bronchiectasis has its origin in childhood, it is desirable that the diagnosis be made as early as possible. Not only do many young adults tolerate operation better than older ones, but the disease usually is more localized.

Preparation of the patient is important. It has been our practice in the last year to have these patients in the hospital for at least a week before operation. During that time they are treated with inhalations of nebulized penicillin in amounts of about 150,000 units a day. This procedure has been helpful because it temporarily reduces the quantity of secretion from the lung, so that the operation is associated with much less risk and difficulty.

The results of lobectomy are gratifying. The patient is relieved of the cough and foul expectoration that have made him a social outcast. He is rid of the infectious process that has made him chronically ill. Children are permitted normal growth and development not possible in the presence of the disease. In fact, surgical treatment for bronchiectasis has been one of the happiest developments in the field of thoracic surgery.

PULMONARY ABSCESS

Although most pulmonary abscesses can be treated by more conservative means, some of the more extensive and complicated pulmonary abscesses should be considered for pulmonary resection. Multiple abscesses involving one lung very often can be treated most effectively by resection. In many cases in which pulmonary abscess has been present for a considerable period, that is, more than twelve weeks, the lesion is best treated by resection, since prolonged infection will result in bronchiectasis and, even though the abscess itself may heal with external drainage, a residual pulmonary infection or chronic disability will result. I am convinced that in many instances of abscess of the lung pulmonary resection offers the most conservative and effective method of treatment available.

PULMONARY CYSTS

Pulmonary cysts may be congenital or acquired; they probably are usually acquired. I shall not go into the etiology at this time. These cysts may be present for years without producing symptoms or changing much in size. They are dangerous, however, because they may become infected at any time. The only logical treatment for cysts of the lung is pulmonary resection because this provides the only means of complete removal of the diseased portion. Drainage of these cysts is totally inadequate. Pulmonary cysts become infected very easily; hence, it is advisable to carry out a surgical procedure before infection develops, since a more conservative and safer operation can be carried out under these circumstances.

PULMONARY TUBERCULOSIS

Pulmonary resection in the treatment of tuberculosis recently has achieved some favor. It has definitely established a place for itself in the treatment of pulmonary tuberculosis, but further study in a large number of cases must be carried out before the indications or contraindications can be stated definitely.

It is impossible to lay down a clear-cut list of indications for resection for tuberculous lesions of the lung at present, because the field is in a stage of rapid development. On the basis of present evidence, it seems likely that pulmonary resection will find greatest application under the following circumstances: (1) treatment of active parenchymal tuberculosis complicated by bronchial tuberculosis and stricture; (2) extensive basal tuberculosis, with or without associated bronchiectasis; (3) pulmonary tuberculosis that has not responded to adequate collapse by either pneumothorax or thoracoplasty; (4) treatment of large cavities in unilobar or extensive unilateral disease; and (5) tuberculoma. Further experience may re-

sult in addition to or subtraction from this list of indications. These are largely the indications outlined by Overholt and Wilson.[1]

It should be pointed out that, for the most part, the aforementioned conditions constitute those in which the existing method of treatment has not been satisfactory. In other words, resection is an addition to the older methods of treatment and is not, to any great extent, competitive with them.

Although lobectomy and pneumonectomy usually are considered together in discussion of pulmonary resection for tuberculosis, it should be pointed out that the indications for each are very different. Pneumonectomy never can be a procedure of choice from the functional standpoint, and its use should be limited to those cases in which collapse is inadequate or would be unsatisfactory because of the pathologic characteristics of the tuberculous process. Pneumonectomy probably will find its broadest application in cases in which there has not been satisfactory response to other collapse procedures and in cases in which it is generally agreed that successful treatment by other means is not possible. Lobectomy may have to compete, to some extent, with thoracoplasty and other well-established procedures. Lobectomy has the advantage in that it can be carried out in one operative session, whereas thoracoplasty requires two or more. Lobectomy accomplishes removal of the gross tuberculous lesion and does not deform the thoracic cage, as it is necessary to do in thoracoplasty. Repeated refills of air are not necessary. The chief hazards of lobectomy are tuberculous complications, that is, bronchial spread of the tuberculosis and the development of bronchial fistula and empyema. These hazards have been largely overcome by the improvement of technique. It is important that pulmonary resection for tuberculosis be performed by a surgeon who has had considerable experience with the entire field of tuberculosis therapy, so that those patients who are to undergo operation can be chosen carefully, with full appreciation of what other more conservative procedures might accomplish.

It is impossible at this time to evaluate accurately the results of resection of the lung for tuberculosis, because the cases in which operation have been performed are too few and the period that has elapsed since operation is too short to allow an estimate of the prognosis. However, it would be very unwise to condemn the procedure merely because the results in the past have not been encouraging. More recent experience, with improvement in technique, is in sharp contrast with the poor results in earlier reports. Further experience in the selection of patients for operation and the time for operation, and improvements in the technique of operation and in preoperative and postoperative management, will produce additional improvement in the results.

It is apparent to all those interested in tuberculosis therapy that there are limitations to the effectiveness of all collapse therapy used for tuberculosis, and that there are several types of patients who are not amenable to any kind of conservative treatment. Patients should not be denied the benefit of surgical resection if it offers a reasonable chance. I am convinced that with the development of newer antibiotic agents, resection in the treatment of pulmonary tuberculosis will become a field of increasing usefulness.

REFERENCE

1. Overholt, R. H., and Wilson, N. J.: Pulmonary Resection in Treatment of Tuberculosis; Preliminary Report, J. Thoracic Surg. 14:55-82 (Feb.) 1945.

MANAGEMENT OF THE MENOPAUSE AND CLIMACTERIC

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The term "menopause" literally means cessation of menses; "climacteric" and "climacterium" are derived from the Greek word meaning "rung in a ladder," hence a step in the aging process of woman. The latter terms are probably preferable to "menopause" to describe the phenomena generally implied, though by common custom all these terms are used to describe that period of a woman's life marked by cessation of menses and certain more or less characteristic symptoms.

Women are subject to the likelihood of one or more of a multitude of difficulties at this time; some arise as the result of real physical disease or actual physiological change, and others are largely of psychogenic origin. It must be remembered, however, that most women experience only mild physical or emotional upset and consequently require no treatment whatever. Novak questioned 100 of his patients who had passed through the menopause and found that 72 had not had symptoms severe enough to consult a doctor. In fact, some women seem to blossom out at this time and state that they are happier and feel better than ever before. In some instances this may result from the relief from fear of pregnancy and further childbearing and from lessening family responsibility as the children grow up and leave home.

Read before the Section on Obstetrics and Gynecology, State Medical Association of Texas, Annual Session, May 7, 1946.

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When the patient presents herself to the physician, she has, to her, a very real reason for doing so; this complaint deserves careful attention. The general practitioner or the internist is more likely to be consulted for relief from the vasomotor symptoms or other largely subjective difficulties. The gynecologist's patients will include more of those women who complain of abnormal bleeding, discharge, pelvic discomfort, or because they fear changes which may occur in the genital organs at this so-called "change of life." Regardless of complaint, a good history and physical examination is prerequisite to proper treatment of these patients. The history may reveal psychic disturbances — fears and maladjustments — which call for reassurance. The history includes an account of menstruation, fertility, childbearing, or past genital disease.

Physical examination is of even more importance than history. This is an age group in which there is increased incidence of degenerative disease and the highest incidence of genital and breast malignancy. Nearly all such malignancies are of such nature that the appearance of symptoms denotes at least a moderately advanced lesion. Improvement in survival rates for such cancer in the last two decades has resulted from more early diagnoses rather than from improvements in therapeutic technique. Diagnosis after the appearance of discharge, pain, a large tumor mass, or prolonged bleeding is almost never an early one. History and examination to rule out present or past breast or genital malignancy is prerequisite to administration of any estrogenic substance; these drugs should probably not be given in cases in which such malignancy has existed or where it is suspected.

General examination may reveal evidence suggesting nongynecologic disease which should be investigated by a physician better qualified in that particular field. Such investigation is preferable to the practice of attributing all sorts of symptoms to the "change of life," thus delaying treatment of a serious disease.

The physician assumes great responsibility in giving a patient assurance that no cancer exists; hence he must do everything possible to verify such an opinion. This assumes increasing importance as more women seek periodic prophylactic examinations as the result of cancer-prevention publicity.

Certain salient features of the physical examination deserve emphasis:

1. *Breasts.*—Since the breast is one of the four most common sites of cancer in women, any nodule should be investigated, and by all means a single painless one.

2. *External Genitalia and Vagina.*—Atrophic changes may be present, though they are usually not marked until later years when actual genital senility is present. There may be enough atrophy to cause vaginitis; this may be the chief complaint and can be readily relieved by the use of estrogenic suppositories. A suggested method is to use one .5 mg. diethylstilbestrol suppository daily for two weeks, followed by daily insertion of a No. 11 veterinary capsule filled with beta lactose 80 per cent and boric acid 20 per cent for another few weeks. Continuous treatment with estrogens is inadvisable, but the course can be repeated if symptoms recur. Leukoplakia, kraurosis, and carcinoma of the vulva are far more common after genital senility appears. Primary carcinoma of the vagina is rare, but does occur at this age; a careful examination of the vaginal wall may reveal a symptomless lesion.

3. *Urethral Orifice.*—Caruncle may be present, but contrast between the darker red color of sagging urethral mucosa and the paler atrophying vulval mucosa may be mistaken for caruncle.

4. *Relaxations of the pelvic floor* are mentioned in this discussion only to call attention to the fact that the woman who has recently ceased menstruating is probably at an optimum time for repair; she is past the childbearing age and yet robust enough to be a better surgical risk than she will be later.

5. *Cervix.*—The cervix requires a careful examination in keeping with its importance as a site of cancer and because symptoms appear late in the disease. Examination should be made in a good light and with a speculum large enough to expose the entire portio vaginalis. Erosions are examined by biopsy when any doubt exists, but granular appearance, contact bleeding, and particularly hardness and induration of one area call for biopsy always. Multiple biopsy specimens are of far greater value than a single one. An area which persistently fails to heal after cauterization is to be regarded with high suspicion and examined by biopsy. Staining the cervical epithelium with Lugol's solution as suggested by Schiller may be of some value in choosing biopsy sites, but the staining is often misleading. Carcinoma arising within the cervical canal, whether squamous cell or adenocarcinoma, is especially liable to be overlooked; there may be no visible evidence of the lesion, yet extensive involvement of cervix and parametrial tissues may have already occurred; rectal ex-

amination may reveal fixed, indurated broad, and utero-sacral ligaments when no other evidence exists.

6. *Fundus.*—Small fibroids at the menopause may be kept under observation for enlargement. Those 8 to 10 cm. and larger are preferably removed by total hysterectomy. When bleeding is attributed to the presence of fibroids, diagnostic curettage is mandatory before resorting to irradiation castration. Also, examination must determine beyond little doubt that the tumor is fibroid, that is, not an extra-uterine tumor which may very well be malignant; irradiation castration in such a case will lead to serious delay in urgently needed surgery. The primary responsibility for differential diagnosis is the referring physician's, only secondarily the radiologist's.

Abnormal bleeding always arouses suspicion of disease of the fundus. Excessive bleeding or recurrent intermenstrual bleeding at this age requires diagnostic curettage. Microscopic examination of such endometrium may show only one of the various stages of normal endometrium, or hyperplasia, and in such cases the bleeding is considered "functional" and not of malignant origin. However, the recent investigation of Corscaden and associates suggests that perhaps there is a higher incidence of subsequent cancer of both fundus and cervix among women who have functional bleeding at the menopause.

When curettage is done in these bleeding cases, thorough scraping of both uterine cavity and cervical canal is done. I have found a medium-sized bone curette preferable to a uterine curette for scraping the cervical canal; a cervix in which no cancer exists yields little or no tissue.

7. *Ovaries.*—These are examined for presence of cyst or tumor. Any solid tumor is to be removed; any cystic tumor is under suspicion and if larger than a lemon is to be removed.

8. *Chronic pelvic inflammatory disease* usually subsides at this time, though residual damage may occasionally call for surgery.

9. *Endometriosis* always subsides after cessation of ovarian activity unless reactivated by administration of estrogens.

If examination reveals no abnormality other than possibly early atrophic changes, symptoms being entirely subjective, further evaluation of the patient's difficulties may indicate what therapy may promise greatest relief. In some patients the symptoms may be predominantly of psychogenic origin, or an exaggeration of preexisting complaints by the physical discomfort and fears created by changes occurring at the menopause. Assurance and an explanation of what happens at the menopause is of paramount importance to such patients. The thoroughness of physical examination adds weight to such assurance. The patient then knows that she is free of cancer and that she is experiencing a perfectly normal phenomenon. Phenobarbital, grains .25, before meals and at bedtime may be all the medication indicated. However, if hot flashes (of the head and neck especially, often followed by sweats), hot flashes over the body, or similar vasomotor symptoms are prominent, it is desirable to institute a plan of estrogen therapy.

Hormonal changes known to occur at the menopause are associated with decreasing ovarian activity. The ovaries have aged to such a point that they no longer respond to stimulation by gonadotrophins secreted by the anterior pituitary, or at least response is only partial; follicle maturation and luteinization are incomplete; ovulation may occur with less regularity or not at all. There is a fall in estrogens present in the blood, but a rise in gonadotrophins. These changes are reflected in menstruation by irregularities—periods may be missed or become scanty, or perhaps excessive bleeding may occur. Continued bleeding or intermenstrual bleeding calls for diagnostic curettage, as the bleeding differs in no way from the bleeding of malignancy. Further diminished ovarian activity leads to complete cessation of menstruation; this sometimes occurs suddenly. Pregnancy is to be suspected in such cases as it often occurs as a result of relaxed contraceptive precautions, the patient believing herself beyond the fertile years. Ovarian secretion of estrogens may continue for some time after cessation of menses. In some women there is evidence that estrogens may be formed elsewhere, probably in the adrenal cortex.

The aim of estrogen therapy is not at total replacement nor at suppression of the excess gonadotrophins. (There is lack of agreement as to whether the symptoms of the climacteric are caused by lack of estrogens or excess of gonadotrophins.) In the first place, symptoms are relieved by doses far less than are required to accomplish a hormonal correction. In the second place, the purpose of estrogen therapy is to help the woman through this period of adjustment to her postmenopausal hormonal physiology—to let her down gently. Large doses of estrogens over a long period of time only delay this adjustment.

A discussion of this type cannot include a comparison of all the varieties of natural and synthetic estrogens available. The synthetic ones are appreciably cheaper, and most wom-

en who respond to estrogen therapy are relieved as well by them as by the more expensive natural ones. Diethylstilbestrol is a cheap and satisfactory substance and is effective orally. Dosage is usually .1 to .5 mg. daily by mouth, generally equivalent to intramuscular injection of 2,000 to 10,000 international units of natural estrogens. It may be desirable to initiate therapy by intramuscular injection of the substance in oil two or three times weekly to obtain full therapeutic effect, then to change to oral dosage. Ethinyl estradiol, another synthetic product, enjoys a current popularity; a dose of .05 mg. is equivalent to .5 mg. of diethylstilbestrol. Some patients are relieved of hot flushes by synthetic drugs, but fail to obtain quite the sense of well-being they experience when given natural estrogens; there is no reason to deny these patients the substance from which they obtain the greatest comfort. The conjugated estrogens obtained from pregnant mares' urine and occurring as sodium estrone sulfate are efficient natural estrogens now popular.

The dosage for any one patient is determined simply by the relief obtained; there is no reason to give less in the beginning, and it is undesirable to give more. Symptoms of overdosage may be bleeding, unpleasant breast swelling, leukorrhea, or an unwanted increased libido. Therapeutic effect may be measured by observations on the cytology of vaginal epithelial cells; this is interesting and occasionally valuable, but usually unnecessary. After symptoms are relieved, what should be a maintenance dose? *There should be no maintenance dose.* Treatment is best discontinued from time to time, say one week out of four, or ten days out of thirty. Also, repeated efforts are made gradually to reduce the dose. A therapeutic program which observes these two points will afford adjustment of most women in from six months to a year, sometimes longer, even to three years. A mild sedative such as phenobarbital is a useful and almost routine adjunct to estrogen therapy. Thyroid may enhance the feeling of well-being if hypothyroidism exists.

There are contraindications to the use of estrogen. Any woman who has had cancer of the breast or genitals should be given estrogens cautiously, if at all, and only if her menopausal symptoms are quite severe and cannot be relieved in any other way. It is believed by some that no woman with a family history of such cancer should receive estrogens.

Endometriosis is a relative contraindication; anything but a very small dose may reactivate the lesions with resultant return of pelvic pain. Relief follows cessation of the drug. Androgenic substances have been useful in these cases, giving rise to relief of vasomotor symptoms without activating the disease.

Withdrawal bleeding in the course of therapy is less common when moderate doses are used and regular rest periods are a part of the program, but sometimes it does occur. In such event, the drug is discontinued until bleeding has stopped; then treatment is resumed with a smaller dose. It may be advisable to change from synthetic to natural estrogen in some cases. However, if bleeding fails to stop in a reasonable time, diagnostic curettage is indicated.

A few women may fail to obtain relief from assurance, sedatives, and estrogens; these persons probably have psychic or socioeconomic problems which call for investigation and treatment by a psychiatrist.

CONCLUSION

It is emphasized that when a woman consults her physician because of symptoms which appear at the time of or near the cessation of her reproductive life, such symptoms may be caused by the hormonal adjustment which is taking place, or may be evidence of degenerative or neoplastic disease. In either event, the physician performs a valuable service if he makes a thorough examination. Only in this way is he able to discover early cancer or, in the absence of organic disease, give a patient the assurance on which successful therapy is based.

Estrogens are now easily obtained, cost little, and are easily administered, hence are frequently given or taken carelessly. There are contraindications to be observed. The administration of estrogens to women in the menopause can be based on a clear-cut indication—deficiency—and afford an invaluable aid to the distressed patients, but it must be recalled that they serve as a temporary crutch and as such should be discarded when their support is no longer needed.

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ABSTRACT OF DISCUSSIONS

Dr. Karl John Karnaky, Houston: Being charged with running a menstrual-disorder clinic, I have tried many things. Menopausal symptoms send a patient to a gynecologist at a time of her life when disorders may be found—especially senile vaginitis. I have tried almost every drug known for this. A review of 5,000 cases of ulcerated cervicitis treated at Jefferson Davis Hospital revealed no cancer. If the cervix is treated more good has been accomplished than if something unnecessary is done. It is of no value whatsoever to alter the pH on these patients, however. Only after three to ten months of stilbesterol does the patient regain the higher type of epithelium.

Dr. Allen L. McMurrey, Houston: This condition seems to be just as involved as ever. It seems the obstetrician can deal with a problem of third degree laceration better than with one of the endometrium. The important thing is that the involvement is more with the cessation of ovarian function than with the cessation of menstruation. Even when a patient is treated with enough roentgen rays to have cessation of the menses, there is not alleviation of symptoms. It is necessary to abolish completely all hormonal function. The treatment of this condition has been very discouraging.

Dr. Devereux, closing: The disturbances at the time of the menopause do bring patients in when they should be examined. With regard to the references made to the endometrium: The fact is emphasized that ovarian secretion does not necessarily cease at the time menses cease. It may be derived from the adrenal cortex. The dosage of testosterone must be gauged by the patient's needs rather than by milligrams. Testosterone has been used frequently with good results in relieving vasomotor symptoms.

ULTRAVIOLET RADIATION AND INFECTIONS

Committees of the National Research Council and the American Public Health Association have recently submitted separate reports indicating that the use of glycol vapors or ultraviolet radiation to reduce airborne infectious diseases, particularly of the upper respiratory tract, is still in the experimental stage, and installation of such equipment in public buildings and industry in the hope of cutting down such infection is not warranted. The National Institute of Health has conducted similar studies and concurs with the two reports. The National Institute of Health, in issuing a statement regarding the matter, emphasized that direct unshielded ultraviolet radiation of sufficient intensity to kill microorganisms in the air is also harmful to the eyes and exposed skin of human beings.

BEAUMONT GENERAL HOSPITAL TREATS CANCER

Although cancer was not a major problem at any time during World War II, the Army Medical Department still operates four deep x-ray centers where patients are treated, the Army Surgeon General reports. Beaumont General Hospital, El Paso, is one of the centers which still maintains this type of treatment and has available medical scientists who will continue to study the disease for the welfare both of the Army and of civilians.—S.G.O. Notes, Jan. 15, 1947.

THE Rh FACTORS IN HEMOLYTIC DISEASE OF THE NEWBORN

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This paper is a review of the literature on the Rh factors in hemolytic diseases of the newborn in an effort to present the most salient facts that are of interest to the clinician. The Rh factors may be defined as substances in the red blood cells which act as antigens when they come in contact with blood which does not possess these factors. The Rh factors are present in the blood of about 87 per cent of white Americans. They are in the blood of a much higher percentage of Negroes and Orientals. The persons whose blood contains the Rh factors are termed Rh positive, and those whose blood does not contain them are termed Rh negative. The incompatibility between the Rh negative blood of a mother and the Rh positive blood of her fetus produces hemolytic disease of the fetus or newborn, which has been referred to as erythroblastosis fetalis, or icterus gravis. The triad from which hemolytic disease occurs in about 92 per cent of instances is an Rh negative mother, Rh positive father, and Rh positive infant. In about 8 per cent of cases the Rh factors may, or may not, be responsible for the disease. Hetero-specific pregnancies play a part in this small percentage of cases. For example, if the mother has blood in group O and the baby in group A, the mother may become sensitized to group A cells, and anti-A agglutinins from the mother will hemolyze the infant's red blood cells. Polayes[8] reported 2 cases of this exact incompatibility in 1945. This type of incompatibility may occur coincidentally with Rh incompatibility.

Through a break in the villi of the placenta, even microscopic in size, the Rh positive blood of the baby enters the circulation of the mother. The mother's blood reacts against this antigen in the red cells of the baby and produces antibodies against it. This process of antibody formation in the mother's blood is called immunization, isoimmunization, or sensitization of the mother to the Rh factor in the baby's blood. These anti-Rh agglutinins produced in the mother's blood enter the baby's blood and hemolyze its red blood cells.

It was formerly thought that in the first pregnancy there is usually not enough immunization of the mother to bring about hemolytic disease in the baby, nor in the second, but that in the third and later pregnancies the disease is a frequent occurrence.

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It has recently been shown by Boorman and associates[1] that in 77 families involved with Rh incompatibilities 4 had hemolytic disease in the first born. In March, 1946, Levine and Waller[6] reported 28 instances of this disease in first born Rh positive infants, in a study of 700 Rh negative women in the years from 1940 to 1945. The mothers in 19 of these cases gave histories of one or more transfusions prior to the first pregnancy, and in 9 no history of previous transfusions could be obtained. Certainly transfusion of Rh negative females with Rh positive blood at any time of life prior to the first pregnancy is a potent factor in hemolytic disease or hydrops of the first born.

The disease is sometimes brought about by an atypical agglutinin designated by Levine as anti-Hr. The Hr factors are the least encountered of the Rh groups, but the most spectacular. Sixty per cent of Rh_1 bloods of white persons and almost all Negroes possess the Hr factors, according to Waller and Levine. Only about 20 per cent of the white population are Hr negative[11] and may be sensitized. The incidence of hemolytic disease is only 1 in 150 to 200 random full term deliveries, according to Levine; this figure is based on Rh tests and not on clinical grounds only. Sensitization to the Hr factors seldom occurs because they are thought to be less potent antigens. In fact, it has been estimated that "less than 3 per cent of cases of erythroblastosis are due to Hr incompatibility."[10] The Hr factor seems to be the property most often involved in hemolytic disease where the mother is Rh positive. It is considered quite probable that the Hr factors are involved primarily in heredity rather than as a result of transfusion immunization. "Hr serum is very valuable in medicolegal work. In disputed parentage cases it may be the key to the identification of the suspected father or it may prove that a man could not possibly be the father of a certain child."[7] Anti-Hr serum is also of some value in giving parents who have had one or more erythroblastotic infants a prognosis as to future pregnancies.

The question might be asked why an Rh negative infant of an Rh negative father and Rh positive mother cannot have hemolytic disease. The answer is that the infant is Rh negative and has no antigen in its blood to stimulate antibody formation in the mother. As far as known the antigen must come from baby to mother, rather than from mother to baby.

A case of hemolytic disease in which father, mother, and infant were all Rh positive was recently reported by Docter.[2] This case was classified by Davidsohn as an atypical case because the patient's blood contained anti-Rh agglutinins of an atypical type. This is one of the few cases in which anti-Rh agglutinins have been reported found in a baby's blood. Heterozygous fathers, that is, those who inherit the Rh factors from one parent only, are less likely to transmit the Rh factors to their offspring than homozygous fathers, that is, fathers who inherit these dominant hereditary blood factors from both parents.

Levine[5] found 10 per cent of 350 mothers of infants with hemolytic disease to be Rh positive, 100 per cent of 204 husbands Rh positive, and 100 per cent of 138 affected infants Rh positive. Apparently Rh negative babies do not have the disease as a result of Rh incompatibility.

The symptoms of hemolytic disease of the newborn are rapidly increasing jaundice which appears at or within a few days after birth, enlargement of liver and spleen, and pallor of mucous membranes. The red blood count falls rapidly within a few days, sometimes within a few hours down to 1,000,000 or less, and there are many nucleated red blood cells. Hemoglobin falls to 20 per cent or less and at times cutaneous hemorrhages are seen. The infants are weak and listless. The white blood count may be increased up to 30,000 or even 50,000, with a high percentage of polymorphonuclears, or it may be normal. The prothrombin time is greatly increased up to 120 seconds. Normal is 12 to 15 seconds. A yellow vernix caseosa or liquor amnii should arouse suspicion. The diagnosis is usually made from the symptoms and by Rh typing of the father, mother, and infant. Antigenic differences between mother's and infant's cells plus the anti-Rh agglutinins in the mother's serum will usually confirm the diagnosis.

Hydrops fetalis is the most severe form of the disease. The infant with this condition is stillborn or dies very soon after birth. The longest life period recorded is six days. About 75 per cent of patients with hemolytic disease recover with prompt treatment. The hydrops infant presents a waxy skin, marked edema, and hemorrhages. The face is swollen, neck short, and abdomen markedly distended. The diagnosis can be made prenatally by checking the rise in titer of anti-Rh agglutinins in the mother's blood.

Hemolytic disease of the newborn occurs in about .1 per cent of all pregnancies, according to Potter and associates. Other writers have stated that it occurs in .2 to .25 per cent of pregnancies. The expected incidence would be much higher since about 13 per cent of all marriages are between Rh negative women and Rh positive men, but the

current tendency toward small families reduces the chance of isoimmunization by several pregnancies. Also, Rh negative women vary in ability to produce antibodies in response to the stimulus of the Rh positive cells of their fetuses. It is calculated that only 1 in 25 to 50 Rh negative persons exposed to Rh positive blood becomes sensitized to an Rh factor. There are also variations in the permeability of the placenta, which may hinder or facilitate the passage of the Rh positive red cells from the fetus to the mother, and specific antibodies from the mother to the fetus. The anti-Rh agglutinins also vary in power to hemolyze the baby's blood. Recently Goldbloom and Lubinski[3] reported a case of a mother who was Rh negative, whose husband was Rh positive, and whose third child was Rh positive, but the infant showed no signs of hemolytic disease. These authors mentioned 8 other cases in which the finding of anti-Rh agglutinins in the mother's serum was accompanied by more or less severe hemolytic disease in the baby. In some pregnancies it is probable there has been no interchange of blood between the mother and fetus.

Heterozygous fathers do not transmit the Rh factors to all their children, and the child who does not inherit the factor escapes the disease. Recently a case of the disease was reported in an Rh positive twin, while the other twin was Rh negative and was not affected. Race and Taylor[9] stated that the majority of fathers of erythroblastotic babies are homozygous, which would reduce considerably the incidence of the disease, since only about 43 per cent of all Rh positive persons are homozygous. Homozygous Rh positive men practically always transmit the Rh factors to their offspring.

Treatment is transfusion of Rh negative group compatible blood, about 10 cc. per pound of body weight, as often as necessary until the red blood count is brought up to normal. Investigators of this disease agree that mother's blood cannot be used because of its iso-agglutinins, which would destroy the baby's Rh positive cells. Father's blood cannot be used because it is Rh positive and the antibodies which the baby has received from the mother and which are destroying the baby's blood will also destroy the father's Rh positive red cells and the baby would therefore receive no benefit from such a transfusion. Furthermore the transfused Rh positive cells will continue to be hemolyzed in the infant and further damage the infant's kidneys, as mentioned by Drs. Hill and Haberman of Dallas.[4]

Taking the baby off the mother's breast milk may be of some value, as Hill and Haberman[4] have demonstrated anti-Rh agglutinins in milk of mothers of erythroblastotic infants.

There is no exact prophylaxis against hemolytic disease of the newborn except the mating of Rh negative men to Rh negative women. Marriage of Rh negative men to Rh positive women, and Rh positive men to Rh positive women is fairly safe, but here the Hr and other factors are to be reckoned with occasionally. Of course, the worst combination in marriage is an Rh positive man with an Rh negative woman. Avoidance of intramuscular blood injections to newborn infants and refraining from giving transfusions of Rh positive blood to Rh negative women are of great value as prophylactic measures. The father and mother should have Rh typing done and if the father is positive and the mother negative an Rh negative donor should be held in readiness because it is necessary to move quickly in the treatment of hemolytic disease of the newborn.

Knowledge of the Rh factors is of great value in preventing hemolytic reactions in blood transfusions. Before discovery of the Rh factors blood properly typed and cross-matched was considered safe for transfusion, but in spite of all that, reactions did occasionally occur in intragroup transfusions. The safety factor has been that most persons receive only one transfusion, and 56.6 per cent of all white people belong to the same Rh pheno-type, namely Rh_0' according to Weiner. Rh typing in both the donor and recipient should always be done. An Rh negative male should not be transfused with Rh positive blood if an Rh negative donor can be had. However, in case of emergency, an Rh positive donor can be used until an Rh negative donor can be found. If the patient is transfused the second or third time with Rh positive blood, there may be produced sufficient anti-Rh agglutinins in his blood to destroy the Rh positive blood from the donor so that he receives little or no benefit from any transfusions after the first. He may also have a severe hemolytic reaction. An Rh negative female should not be transfused with Rh positive blood even once because of the danger of her blood reacting with the formation of anti-Rh agglutinins which, if and when she becomes pregnant, will give her fetus, if Rh positive, a double dose of blood destruction. If her fetus is Rh negative, of course no harm will come of it.

In spite of all of the good that has come out of the therapeutic application of what is known about the Rh factors, it is still necessary to contend with kernicterus, which is the neurologic sequela of hemolytic disease of the newborn. It has long been known that there

is a definite relationship between jaundice of the newborn and pigmentation and degeneration of the cells of the brain, particularly of the basal ganglia. Before the Rh factors were known and treatment with transfusions saved many babies very few of the infants survived to present neurologic signs and symptoms a little later in life. Very few cases of kernicterus have been reported in diseases other than hemolytic disease of the newborn. The pathogenesis of this sequela is not clearly understood. The condition may be the result of poor oxygenation of the developing fetal brain cells because of destruction of the red blood cells by iso-agglutinins from the mother, or it may result from some harmful product of red cell destruction. Ischemia of the areas involved is thought by some to play a part. Some investigators believe the iso-agglutinins may have a specific affinity for or toxic action on the basal ganglia cells. If the little patient survives the neonatal period, there may soon develop evidence of kernicterus, namely, spasticity, athetoid and choreiform movements, mental retardation, and convulsive seizures. Pathologically, the important lesion is demyelinization and degeneration of the nerve cells, the pigmentation being of secondary importance. This terrible aftermath of hemolytic disease of the newborn has been reported as occurring in from 38 to 55 per cent of infants who survived the acute disease.

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ABSTRACT OF DISCUSSION

Sol Haberman, Ph. D., Dallas: The problem of the Rh factor and its importance in obstetrics and pediatrics cannot be reviewed too often. Dr. Nunn has presented an excellent condensed review of the subject, laying stress on many of the important features brought out in the literature. As has been mentioned, prompt therapy of erythroblastotic children is indicated. This therapy consists of Rh negative transfusions and removal of the infant from the breast. The rationale of this is to give blood that will not be affected by the antibodies already present in the child's circulation so that unimpaired oxygen transfer may be maintained in the tissues. And by using formula feedings, the antibodies present in the colostrum will not be transferred to the child. Therapy of this type should be instituted in all cases where Rh antibodies are demonstrable in the maternal serum or on the infant's erythrocytes. Treatment within twenty-four hours of birth lessens the incidence of kernicterus. It should be remembered that not all Rh negative mothers bearing Rh positive children will become sensitized to this antigen. In our studies, it was found that only 7.9 per cent of Rh negative mothers gave birth to erythroblastotic infants. In a paper by Dr. J. M. Hill,* statistics on a routine Rh typing service are presented. In this report it was found that before routine Rh testing was instituted in the Florence Nightingale Maternity Hospital, only 1 case of erythroblastosis in each 600 births was diagnosed. After the institution of routine Rh typing of all mothers and infants, this incidence was raised to 1 case of erythroblastosis in each 363 births, and later with improved techniques an incidence of 1 in 117 births was found. This demonstrates that the routine Rh testing on such a service improves the diagnosis of this disease and thereby serves as an important adjunct to the practice of pediatrics.

*Hill and Haberman: Texas State J. Med. 42:193-197 (July) 1946.

THE GLAUCOMA PATIENT

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Any discussion of glaucoma should remind opthalmologists that they are confronted by a continuing and difficult problem. Glaucoma presents one of the most difficult problems, one which cries out for solution, both as to etiology and management. Chronic simple glaucoma, known as compensating glaucoma easily heads the long list of diseases responsible for adult blindness. Most ophthalmologists are agreed that too little time has been given to the study of the disease and its proper evaluation in undergraduate medical courses. There are various and sundry reasons for this state of affairs. Would it not be better to rearrange the curriculum so as more fully to acquaint the undergraduate with this problem? His time might be better spent if the undergraduate learned only the importance of the early recognition of chronic glaucoma. The incidence of invalids hopelessly blind from glaucoma might then be reduced. Nothing is more disheartening to a surgeon than to have a colleague refer to him a patient for surgery because of a cataract only to find that the patient has clear refractive media but is "totally blind" from glaucoma simplex. Certainly, any patient with previously normal sight complaining of failing vision should have the benefit of an ophthalmoscopic examination by someone qualified to make the test.

Read before the section on Eye, Ear, Nose, and Throat, State Medical Association of Texas, Annual Session, Galveston, May 7, 1946.

It has been said by Spaeth and others that chronic simple glaucoma is not a disease entity but a "symptom complex." In other words, a glaucomatous eye is a sick eye in a sick body. This much is sure. Before anything approaching adequate control of the glaucoma may obtain, the patient himself should have the benefit of a careful clinical study. In some cases this may require the services of a good psychiatrist. Good psychology on the part of the ophthalmologist should be exercised, remembering that every case must be handled on its merits. Above all, frightening glaucoma patients should be avoided. Besides a hard eyeball and progressive blindness, a tragedy that can, in most cases, be prevented or indefinitely postponed, a common symptom noted in nearly all glaucoma patients is an unstable nervous system or some form of anxiety neurosis. This instability may be acquired through the viscissitudes of life or it may be inherited, or both. The evaluation of stress and strain of every day life will frequently reveal that these persons can be helped. Time to do it must be taken. (Experience, not books, teaches this.)

Tension tolerance varies greatly with individual eyes. With some a pressure of 50 mm. mercury (McLean) may be maintained for a year or two before field changes are noted. The height of the pressure is not so important as changes in the field or visual function. Furthermore, the height of the pressure in the low upper normal limits is not so important as the wide fluctuations. It is in these eyes that great damage to optic nerves and retina may occur over a short period of time, with irreparable damage to vision. Repeated field tests must be made, and these may be done as well by a trained nurse or technician as can roentgen ray or other laboratory work. In many eyes the control of the tension does not stop the field changes or eye degeneration. These cases may develop optic atrophy with deep glaucomatous cupping and are very discouraging. Too often neither medical care nor surgery is satisfactory. I believe that every newly diagnosed case should have the medical treatment first, and so long as this controls the condition no surgery should be done. I have had several nervous patients under observation for ten years without the appearance of glaucoma. When it is apparent that medical treatment is failing, the operation should be performed at once. Central visual acuity cannot be depended on as it often remains surprisingly good for a long time. Neither can the height of the tension be depended on. The visual fields are the single most important determining factor. The interval between field taking may vary from six weeks to six months, depending on the progress of a chronic glaucoma. Proper surgery can increase the outflow of the aqueous humor and it can also decrease the inflow. It is not within the scope of this paper to discuss the surgical treatment of glaucoma, but it should be observed that the choice of operation depends on the type of the disease. Whether a deep or shallow angle glaucoma is dealt with will vary the surgical procedures and the after care.

PATHOGENESIS

In acute glaucoma there is a neurovascular crisis with resultant edema. It is known to have followed emotional upsets. In chronic cases the angle is usually blocked either with a hyaline material or with pigment. Some patients have an over-production of aqueous matter. Narrow angle glaucoma patients have an anatomical predisposition and also a definite hereditary tendency. With this, emotional upsets, prolonged darkness which keeps the pupil large, or drugs which do the same thing, or swelling of the lens, may precipitate an attack. Wide angle glaucoma cases may be blocked by inflammatory debris, sclerosis of angle tissue, or by pigment in the angle.

PROPER CARE OF THE PATIENT

As stated above, the first and probably the most important thing to do when confronted by a patient suffering fram glaucoma simplex chronica is to have him consult a skillful clinician. All known or discoverable foci of infection should be treated or eliminated. Endocrine disturbances should be treated and special attention should be paid to hyperthyroidism and arterial hypertension. Emotional disturbances should be controlled, with or without special aid. Mental hygiene, adequate sleeping habits, and proper attention to diet are all most important. Many physicians are at fault in hurrying through their history taking. This habit has been easily acquired by the stress and strain of war time living, or is apt to happen in a too busy practice. More time must be taken with patients, letting them "talk it out." This may require three or more visits but it is sometimes surprising what can be learned in this way that will be of benefit to the patient. Chronic invalidism of one or more of his immediate family, domestic strife, the uncertainties of economic life, and maladjustments in susceptible persons are all thought to initiate attacks and aggravate the symptoms of glaucoma.

But what if the family physician or the internist reports that no sign of organic disease can be uncovered? It seems that all too often the ophthalmologist gets entirely nega-

tive reports from most excellent clinicians. Perhaps in his zeal to render quick and effective aid to the glaucoma victim the ophthalmologist is inclined to overlook an essential fact. The eye *per se* lends itself most readily to detailed objective examination. Biomicroscopic studies by means of the slit lamp will aid in making a differential diagnosis between anterior uveitis and acute glaucoma. But general practitioners or internists have the entire body to consider, excepting the eye. As mentioned above, all or nearly all glaucoma patients have an unstable nervous system. Each case must be handled on its own merits and no general rules can be laid down. None of the "detail men" or vitamin specialists can help in these cases. The patient needs real doctoring by real doctors if any help is to be forthcoming, and too often there is no help even then. These patients are easily excited, and above all the physician must do nothing that will excite them further. The glaucoma patients must be led to understand that the disease is not curable; that they should be under the care of trained ophthalmologists all their lives, and that certain rules of health should be carefully followed. Paradoxical as it may seem, it is sometimes necessary to scare them, to impress them of their fate. Often it is only in this way that the case can be followed up. Some ophthalmologists have a full list of printed rules and give this to the patient to follow. This method has certain advantages, but I am afraid that it may so excite the patient as to do more harm than good. The following are a few rules that I have found helpful in my practice in the conservative medical management of postoperative care:

1. Tension on all patients over 30 should be taken after a drop refraction and while they are under the cycloplegic.

2. Fluid intake, especially coffee, tea, alcohol, or other beverage stimulants, should be restricted. The patient should have at least eight hours sleep daily.

3. Good light for reading or for any close work is necessary; the actual amount of close work under artificial light should be restricted to about four hours at night. Sixty foot candles of light should be the minimum requirement for reading.

4. Picture shows are to be discouraged. Generally, the patient should be instructed to use a miotic just before and after going to shows.

5. Laxatives containing belladonna derivatives should be avoided but the bowels should act regularly.

6. Walking whenever feasible, and all other forms of outdoor exercise within the patient's physical range should be encouraged.

7. Proper digital massage of the eyeballs has been found very helpful and should be used in most cases regularly, whether or not the miotics are used.

8. Situations likely to lead to emotional disturbances, anger, worry, excitement, or grief should be avoided.

9. The patient should be advised to return at once if he sees colored circles around light, or the eye becomes inflamed or painful, or the vision blurred or impaired in any way.

10. Teeth should be kept clean and the mouth free from infection.

11. Acute colds should be attended to promptly and nasal blockage avoided.

1022 Medical Arts Building.

ABSTRACT OF DISCUSSIONS

Dr. F. H. Newton, Dallas: I can only emphasize a few of the points brought out by Dr. Griffey. In order of their importance one must closely observe the fields (including board fields), vision, and intraocular tension. If too much dependence is placed on tension alone, the varying tolerance of different eyes will lead to false conclusions and perhaps to ill advised procedures. All ophthalmologists have patients who carry indefinitely a tension of from 40 to 50 (McLean), and retain good fields and vision, while others with tension as low as 30 (McLean), show gradual reduction in fields and vision. The consideration of 40 (so designated by McLean) as the normal upper limit is misleading and may cause a false sense of safety. In fact, a persistent reading of from 30 to 35 (McLean) bears careful watching and the case should be regarded as border line, particularly if associated with beginning enlargement of the blind spots. I have in mind 2 patients with persistent readings of 30 (McLean), with slight enlargement of the blind spots. They were using pilocarpine drops at bedtime routinely as a precautionary measure. Each patient on getting a refill of the pilocarpine prescription received atropine instead; in two days they both developed acute glaucoma in each eye with tension of 60 (McLean). The tension subsided in a few days on miotics and has remained satisfactory since, with one daily instillation of pilocarpine. An emotional or nervous background in the development of an attack of glaucoma is not an infrequent factor. The suggestion of glaucoma to a patient without careful examination is a serious error and yet, believe it or not, such a diagnosis is sometimes made by ophthalmologists without either fields or tonometric measurements, the patient being saddled with continuous fear and the use of drops without proper justification.

Dr. W. J. Woolsey, Waco: I would like for Dr. Griffey to know that most, if not all, of us, believe that his paper is timely in making us glaucoma conscious. Perhaps a similar paper each year would not be amiss.

In appreciation of the scope of Dr. Griffey's essay, I wish to continue the emphasis on early diagnosis, or even better, early suspicion of glaucoma diathesis. I am reminded of Dr. Weeks' eye service wherein the interns and assistant were reminded constantly about the danger of overlooking early glaucoma, and which quite likely they sometimes did. A paraphrase applicable on this point would be, "To know glaucoma is to know ophthalmology." If the experienced ophthalmologists "are confronted by an ever-continuing and difficult problem," how far back in the patient's history can signboards be set up? If the

conscientiously trained observer feels inadequate, what of the patient who feels perfect? Or the family physician burdened with a multitude of problems? Or more to the point, the optometrist who does see and is likely to continue to see most of the eye patients, well or diseased?

The sad result of the above state of medicine is illustrated when 4 patients with bilateral glaucoma in the terminal stages come to an ophthalmologist's office within a few days. Possibly one could shrug this off, but 2 other cases not so easily shirked come to mind. These 2 patients were in their thirties with far advanced damage to one eye within one year after refraction for hyperopia.

It might be appropriate for this organization to set up an active committee for an educational program along these lines.

Dr. Everett L. Goar, Houston: I would like to call to the attention of the section the fact that it is now possible to have tonometers standardized so that the reading may be certainly correct, and so that tonometers thus standardized will give similar readings. This is a very important contribution to ophthalmology. Dr. Peter Kronfeld, 904 West Adams Street, Chicago, now is in charge of this work, and any type of Schiotz tonometer will be standardized there for a nominal fee. I do not know whether the McLean tonometer is susceptible to such standardization.

CLINICAL DISORDERS ASSOCIATED WITH FUNCTIONAL AND ORGANIC DISTURBANCES IN HYPOTHALAMIC AND OTHER MIDBRAIN CENTERS

ARTHUR GROLLMAN, M. D., Ph. D., F. A. C. P.
DALLAS, TEXAS

The hypothalamus and its associated midbrain centers are being implicated in an increasing number of common, as well as infrequently occurring, disorders. Although much remains to be proved to demonstrate the validity of this assumption, there is ample evidence at hand to indicate the probability that disorder of the midbrain may cause many disorders of unknown origin, as well as certain disorders believed to be due to endocrine disturbances. Since the hypothalamus is concerned in many metabolic and reproductive functions as well as in the control of the autonomic nervous system, it is quite evident that a dysfunction of this area of the brain will result in a variety of manifestations suggestive of metabolic, endocrine, or nervous diseases.[4]

HISTORICAL REVIEW

The incompleteness of our knowledge concerning the function of the hypothalamus and midbrain centers is due to the difficulties attendant upon the experimental study of the functions of this area of the brain. However, as early as 1842, Rokitansky had noted that infectious processes involving the base of the brain were often associated with hemorrhages, perforations, and other disturbances of the gastro-intestinal tract.

In 1901, Fröhlich published his classic case report of a patient manifesting arrested sexual development, adiposity of peculiar distribution, unusual skin texture, optic atrophy and blindness of the left eye with bilateral hemianopsia of the right eye which he considered as being caused by a pituitary tumor. Fröhlich's syndrome for a long time was considered as resulting primarily from pituitary dysfunction, but the error of this view is now well established. The symptoms of suprasellar expanding lesions are due primarily to pressure and interference with the function of the hypothalamus and only secondarily to pressure atrophy on the pituitary. Physiological experiment has demonstrated that the wall of the third ventricle contains centers which are concerned in regulation by the autonomic nervous system. It is now generally accepted, too, that this region of the brain is also concerned in various metabolic, endocrine, and psychiatric functions and that the symptoms induced by dysfunction of this part of the brain duplicate those seen when similar disturbances arise from disorders elsewhere.[4]

FUNCTIONS OF THE HYPOTHALAMUS

As already indicated, the hypothalamus may be considered as the principal center in the forebrain concerned with the integration of the visceral functions controlled by the autonomic nervous system. By means of elaborate connections with nuclei in the brain stem, spinal cord, thalamus, and cerebral cortex, the nuclei regulate such diverse functions as circulatory, respiratory, pilomotor, and sexual activity, water, fat, and carbohydrate metabolism, temperature regulation, peristalsis, glandular functions, and other activities under control of the vegetative nervous system. It is also "a motor way station where emotional expression is integrated into behavior patterns on its way out of the muscles and glands."[1] In addition, it acts as a center for those neuroglandular mechanisms which control some of the basic rhythms of the organism, such as the appearance of pubescence, the menstrual cycle, the diurnal rhythm of body temperature, and sleep, as well as for the reception and integration of the visceral somatic responses which normally give rise to the reactions associated with fear and rage. The hypothalamus may thus be looked upon as the central neuroglandular mechanism which controls the basic rhythms of organic life, and it is not surprising, therefore, to find that it is concerned in so many physiological functions and that disorder of the hypothalamic cen-

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From the Department of Experimental Medicine, Southwestern Medical College.

Read before the Section on Medicine, State Medical Association of Texas, Annual Session, Galveston, May 8, 1946.

ters might be concerned in a variety of diverse diseases.[4]

DISORDERS OF THE MIDBRAIN

Various conditions are encountered clinically in which the hypothalamus appears to be primarily concerned.

Disturbance in water metabolism and the development of diabetes insipidus is generally recognized as being due to insufficiency of the posterior lobe of the pituitary. However, this neural component of the hypophysis is connected by nerve tracts with centers in the hypothalamus, and any interference with these tracts or centers results in insufficiency of the neural lobe of the pituitary. Hence, hypothalamic as well as intrasellar lesions can induce the manifestations of diabetes insipidus, and, in fact, most of those encountered clinically are the result of the former type of lesion rather than the latter.

Obesity, as encountered clinically, is not due in most cases to an organic lesion, but is simply a result of overindulgence in food. However, it may, under rare circumstances, be organic in origin. Hypothalamic dysfunction is now generally accepted to be the cause of this symptom rather than hypophyseal insufficiency, as was formerly believed. As a matter of fact, obesity can be induced in the experimental animal by injury of the hypothalamus even after the removal of the interior lobe of the pituitary, nor is it associated with any known condition in which there is an insufficiency of this part of the gland.

That nervous influences are capable of affecting the reproductive cycle is well established. Psychically induced amenorrhea, for example, is a recognized phenomenon. It is now believed that the nervous impulses which control gonadal function are mediated through the hypothalamus. Although many have attributed this control to be via the hypophysis, it is more likely that the hypothalamus induces its effects on the gonad itself, which, to be sure, is dependent for its action on the integrity of hypophyseal function.[4]

In addition to the above manifestations, the hypothalamic syndrome gives rise to complex clinical pictures with psychic (particularly affective) as well as vegetative disturbances involving sleep, body temperature, vasomotor and secretory functions, and so forth. Narcolepsy, diencephalic epilepsy, catalepsy, affective loss of tone, and the Wilson and Korsakoff syndromes are often associated with lesions in the hypothalamus, but it is probable that interference with other parts of the brain connected to the hypothalamus are also concerned in these disorders. An increase in erythrocyte count and alteration of the differential leukocyte count from normal is not infrequent in hypothalamic disorders and may account for polycythemia as seen in the Cushing syndrome.

Among the organic lesions which give rise to the hypothalamic syndrome are tumors within or near the hypothalamus, craniopharyngiomas, and infectious processes such as encephalitis involving the floor of the third ventricle. In addition to these conditions, in which the role of the hypothalamus is evident, and Fröhlich's syndrome, which has already been referred to, the clinical conditions to be discussed in the following paragraph may occur in association with hypothalamic disorders.

Precocious puberty and hypergenitalism is most commonly a result of tumors or disease of the hypothalamus. As observed clinically, these conditions represent instances of true precocity in contrast to the pseudoprecocity seen in involvements of the adrenal cortex and gonads. Cushing's syndrome, which was originally thought to be the result of basophilic adenoma of the pituitary, is now known to originate only rarely from disturbances in the pituitary, but is most often due to lesions in the adrenal cortex. In addition, it is very probable that a certain group of patients manifesting this disorder have a lesion in the hypothalamic area. Metabolic craniopathy or hyperostosis frontalis interna is "a syndrome characterized clinically by variable and protein manifestations of a metabolic, endocrine, and neuropsychiatric nature, and roentgenologically by a characteristic thickening of the internal tables of the skull."[3] Although there is no evidence to prove that this commonly observed condition is due to a functional disturbance in the hypothalamus, the nature of the symptomatology is such as to justify the assumption that this is probably the primary site of the disorder. The same may be said of fibrous dysplasia of the bones.[4]

SUMMARY

Although much remains to be learned concerning the physiological activity of the hypothalamus and its associated centers, it is clear from its manifold activities that it can conceivably play an important role in the causation of many symptoms and manifestations of mysterious origin. There is a great need for a correlation of the clinical findings with those observed at autopsy, and until such studies have been made, knowledge in this field must be based on inference rather than on demonstrated fact. Nevertheless, such information as is at hand begins to explain some of the symptoms and condi-

tions encountered clinically which have been inexplicable heretofore.

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ENDOCRINE PROBLEMS IN CHILDHOOD

MAY AGNESS HOPKINS, M. D.
DALLAS, TEXAS

While even in early times articles regarding the ductless glands appeared, most of them concerned theory and speculation. It was not until the latter half of the nineteenth century that the experimental epoch began. Since about 1882 the research has been voluminous.

While many controversial opinions have been expressed, a few facts have been fairly well accepted. Roskins, after many years of research, said that the child comes under the influence of endocrine factors at the time of conception and remains under the endocrine influence through prepuberal and puberal life. Englebach, likewise after years of study and research, said that the thyroid hormone component of the unfertilized ovum and sperm is an important factor governing the differentiation of the embryonic ectoderm, mesoderm, and endoderm.

Accepting the above stated facts, and making an effort to look for and remedy deficiencies relative to them, has brought me to the conclusion that while answers to all the problems are not yet known, good results can be obtained at times if physicians are interested and on the alert.

Congenital hypothyroidism is an inherited inactivity of the thyroid gland, presumably due to a decreased supply of thyroxin to the fetus. If a hypothyroid deficiency remains unrecognized for too long a period of time, other glands which are interrelated and interdependent also become involved. As a result, children 10 years of age and over have a dual deficiency. If the latter condition remains unrecognized, pluriglandular deficiencies that cannot be remedied appear in adult life. Hence, this subject should interest the pediatrician as a possible type of preventive pediatrics.

If pediatricians are on the alert, they begin with the mother. When called to see a baby or a very young child, they should notice any evidence of a hormonal deficiency in the mother which could be passed on to the child. A careful case history will help to evaluate any hormonal signs that might point to a hormonal deficiency. Such hormonal signs are (1) birth weight more than 8 pounds, (2) delayed separation of the cord beyond the tenth day, (3) inability of the baby to support his head at 6 months of age, (4) delayed dentition beyond 9 months of age, and (5) delayed talking beyond 12 months of age.

The above named symptoms may also be symptoms of such congenital defects as microcephalus or of some birth injury, but ruling these out, the greater percentage of this symptom complex will have as an etiologic basis some hormonal deficiency. Hence such symptoms should be evaluated and either proved or disproved as the result of a hormonal deficiency.

This brings up the question of what has been found to be the best aid in proving any hormonal deficiency.

1. First in importance I place a careful case history, not only of the infant, but, as before said, of the mother—her habits and health during pregnancy—so as to evaluate any hormonal deficiencies the mother may have had that she could pass on to her child.
2. The bone age has been accepted as the next most reliable index. Hence, roentgenograms of the wrist, elbow, ankle, knee, and sella should be made as age may indicate.
3. Blood chemistry is of value. The blood cholestrol will be high in hypothyroid states, ranging as high as 250 to 500 mg. per 100 cc. of blood.
4. Body measurements are an aid to diagnosis of hormonal deficiencies.

The above mentioned hormonal signs should be looked for in the very young.

The older child also presents symptoms, but they are not so well defined or so easy to evaluate. I have in mind children 10 years of age and older who are brought for medical help because they are tired all of the time, listless, and poor students. Another symptom complex appears in the child who is nervous, sleepless, bites his nails, and is a problem child. Still another type is the tall, thin, underweight, listless child, also tired, but mentally alert. Here, as in the very young child, roentgenograms, blood chemistry studies, and body measurements are the best aids to finding a possible etiologic basis.

If the ossification centers appear slow and not developed as they normally should be for the age, the cause is possibly a hypothyroid state. If, to the contrary, the ossification centers are advanced beyond those accepted as normal for the age, a hypogonad or hyperpituitary state should be considered. If the

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ossification centers are normal for the age, a roentgenogram of the sella may give evidence of a pituitary dysfunction. If the patient is a boy, the genital development may point to a hormonal deficiency. If the patient is a girl and a minor hormonal deficiency is overlooked until puberty, failure to mature at the normal age, or menstrual irregularities, may be the key to a hormonal deficiency.

It would be impossible to cover adequately the whole field of endocrine problems in childhood in this short paper. I have tried to point out the more common and everyday patient who comes for medical help.

There are rare and interesting cases, and the literature is replete with such case reports as goiter in a 29-day-old baby, and goiters in other very young children, precocious puberty, difficult cases of hirsutism, and acne. These unusual cases because of their rarity will attract attention and consideration. But if greater interest in this field of pediatrics is fostered, more of the everyday cases of hormone deficiency will be recognized and treated. Thus many hormonal deficiencies in adult life may be prevented

Medical Arts Building.

ABSTRACT OF DISCUSSION

Dr. Harris Hosen, Port Arthur: The most important phase of endocrinology in pediatrics concerns congenital thyroid deficiency. The thyroid gland when deficient presents characteristics of mental and physical retardation and functional nonendocrine system reactions, frequently attributed to other causes. The most important feature in thyroid deficiency is the late appearance of the centers of ossification and epiphyses, which enables one to diagnose this condition natally and postnatally.

The differential diagnosis of hypothyroidism is important in order to exclude those inherent and acquired conditions which might produce a similar syndrome or symptomatology. Three groups are important:

1. Monsters, chondrodystrophies, and hydrocephaluses are usually recognized on inspection.

2. During early infancy such nonendocrine diseases as congenital syphilis, scurvy, rickets, osteogenesis imperfecta, myotonia, and other phases of malnutrition and cerebral injury all result in varying degrees of arrest of physical growth.

Engelbach pictured syphilis and rickets as having a delayed appearance of the centers of ossification, which I could not confirm in work done with Signorelli and Miles. We found the epiphyses in rickets and syphilis to be either normal or early in appearance. This work was published in the *Journal of Pediatrics* in 1935.

Therefore if a case of rickets or syphilis presents a delayed appearance of the centers of ossification, the physician may feel assured that such a case complicates an already existing thyroid deficiency.

3. The inherent group, consisting of idiots, imbeciles, and morons, can be excluded by the normal appearance of epiphyses which occur in these conditions.

HANGING CAST

ROBERT L. SEWELL, M. D.
FORT WORTH, TEXAS

The virtues of the hanging cast for treatment of fractures of the upper humerus have become more and more apparent.

Regardless of whether there is comminution, angulation, over-riding, or any combination of the three, a trial with hanging cast often affords as early a satisfactory reduction as any of the more involved forms of traction.

Perhaps the chief source of discomfort to the patient after application of these weight-

FIG. 1. Photograph showing use of a shoulder sling to support a hanging cast in treatment of a fracture of the upper humerus.

ed casts is the pull of the sling around the neck.

The chief purpose of this communication is to point out that this difficulty can be satisfactorily solved by passing the supporting sling about the opposite shoulder and through a metal ring set at an angle in the cast.

The accompanying photograph illustrates the use of the sling.

1212 West Lancaster.

Headquarters hotels for the annual session, May 5-8, of the State Medical Association and the Woman's Auxiliary. The House of Delegates, general meetings, and most scientific activities of the Association will be held at Hotel Adolphus. The Baker Hotel will be headquarters for the Auxiliary. Both hotels will house special society meetings on May 5.

DALLAS OPENS ITS DOORS TO TEXAS PHYSICIANS

WINSTON BALL, Jr.
Publicity Department, Chamber of Commerce,
DALLAS, TEXAS

Dallas, host city for the annual session of the State Medical Association of Texas, May 5-8, is already a major medical center of the Southwest. But, an alert and progressive city, Dallas is busy with a vast program of medical expansion.

Dallas currently has 19 hospitals with a total capacity of 2,383 beds. There are more than 700 members in the Dallas County Medical Society and more than 250 dentists and more than 1,000 nurses in the city. Dallas is the home of a medical college, a dental college, several schools of nursing, and several major medical libraries.

The Southwestern Medical Foundation was launched in Dallas in 1939 by a group of medical and civic leaders as a nonprofit, nondenominational, and nontax supported corporation to perpetuate medical education and scientific medical research in the Southwest. In 1943, the Foundation established the Southwestern Medical College, through which the purposes of the Foundation might be realized. There are now 96 full-time faculty and staff members, and the clinical faculty is composed of more than 200 specialists.

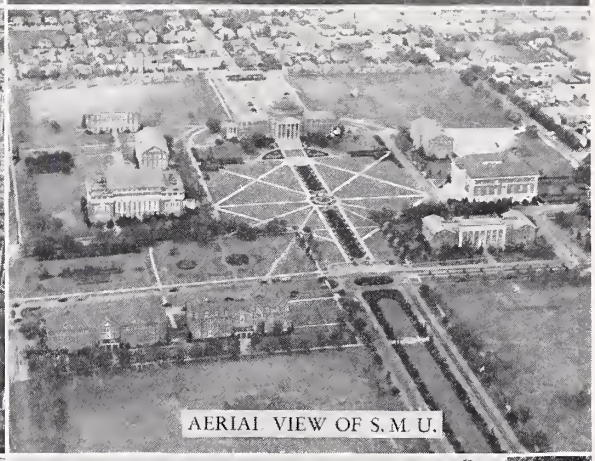
The property of the Southwestern Medical Foundation, located on Hines Boulevard, has about a one-mile frontage and covers over 100 acres. On this site will be located the Southwestern Medical College, the $7,000,000 Memorial Hospital of the City-County Hospital System, and a 500-bed Veterans Hospital. The Foundation has also offered a site for the proposed Dallas State Hospital, which would comprise a cancer and pellagra hospital and a psychiatric hospital.

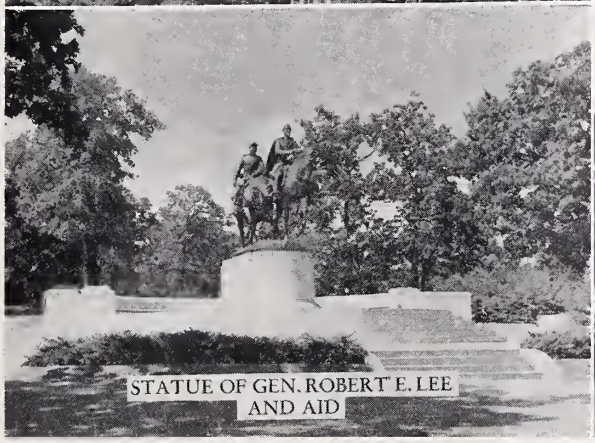
Baylor Hospital, which with 500 beds is the largest hospital in Texas, is the ninety-third largest in the nation. It ranks thirteenth in number of patients, tenth in number of new babies, eighth in number of operations performed, and second in number of pathologic tissues examined among hospitals in the United States. Baylor Hospital has a free diagnostic clinic, and allows 40 beds a day for charity cases.

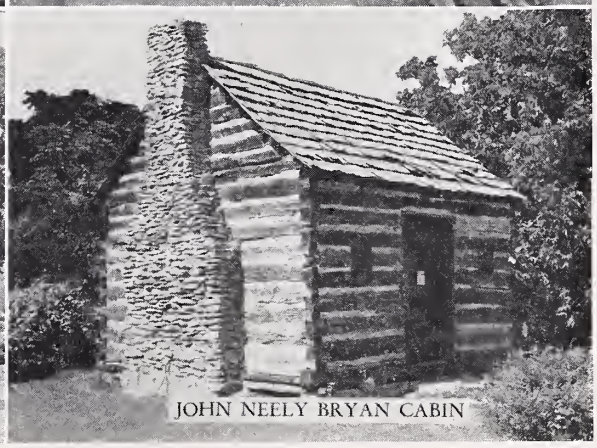
The William Buchanan Blood Center, located at Baylor Hospital, is the first in the country to provide a routine dried blood plasma service. The blood center, among the largest in the United States, also makes whole blood and anti-Rh serum available to hospitals in more than 450 cities in the United States and in 23 foreign countries. It also services the United States Army, Navy, and Veterans Administration hospitals.

Some of the outstanding hospitals in Dallas. Parkland is the general city-county hospital. Methodist, St. Paul's (Catholic), and Baylor (Baptist) are general hospitals sponsored by churches. Florence Nightingale Maternity Hospital is a part of Baylor Hospital, the largest Dallas hospital. The Texas Scottish Rite Hospital is a nonprofit, nonsectarian institution for crippled children.

The Dallas Pediatric Center consists of five institutions, all Community Chest agencies. This center is one of the largest in the United States devoted to the medical care of children from birth to 14 years of age. This service is not duplicated by any other organized group in the South. The center consists of Richmond Freeman Memorial Clinic, which is the out-patient department of the center, and houses the operating rooms, x-ray machines, laboratories and other equipment for the center, as well as all the records; the Bradford Memorial Hospital for Babies, for infants from birth to 2 years of age; the Children's Hospital of Texas, for children from 2 to 14 years of age; Hope Cottage, for dependent and neglected children; and the Dallas Child's Guidance Clinic. All of these divisions work in close affiliation with Scottish Rite Hospital for Crippled







Miscellaneous views of Dallas: The Dallas Health Museum, for the lay public, and the State Fair Auditorium, center of culture and entertainment, both in Fair Park; aerial views of downtown Dallas looking northeast and of the Southern Methodist University campus; a scene in one of the city parks, showing a statue of General Robert E. Lee; and a replica, built on the courthouse lawn, of the trading post log cabin with which Dallas was founded in 1841 by John Neely Bryan.

Children, Southwestern Medical Foundation, and Parkland Hospital. Dallas is also the home of the Parker Foundation for Speech Correction, and the Pilot Institute for the Deaf.

Dallas has two major medical libraries, and several smaller libraries located in the various hospitals for staff use. The largest library in the city is at Southwestern Medical Foundation, and includes approximately 12,000 books, journals, and periodicals. Baylor Hospital Library contains about 7,000 books, journals, and periodicals. These are available to all physicians and dentists in Dallas.

The Baylor University School of Dentistry is located in Dallas, and has an enrollment of about 210 students. Graduate, postgraduate and refresher courses are offered, in addition to the academic work leading to a

D.D.S. degree. A great amount of research in the dental field is constantly being carried on at the school, and widespread recognition is being given work done there.

Dallas is also the home of Baylor University School of Nursing, which has a faculty of ten nurses who are trained not only to nurse but also to teach. After three years of study, certificates of nursing are given to graduates. Postgraduate and refresher work is also given. Parkland, Methodist, and St. Paul's Hospitals also have schools of nursing.

The Dallas Southern Clinical Society was organized in 1929 by the Dallas County Medical Society. The oldest organization of its kind in Texas, the Clinical Society has the slogan: "To make available to the medical profession of the South the postgraduate teaching material of Dallas." Each spring the Society has a clinical conference for postgraduate work in clinics, and includes a series of lectures on rare cases and new techniques. All doctors who are members of their county medical societies are eligible to attend the meetings.

The Dallas Tuberculosis Association has a program of public education and research which includes tuberculin tests of all school children of the tenth grade in the city and county who have the consent of their parents. The entire student bodies of the schools are given lectures and are shown educational films on tuberculosis. The Association will prepare programs and furnish speakers for any organized group in the community, and will also distribute literature and other educational material. In the industrial world, the Association, through the health department, has made a screening test of all food handlers of the city on 70 mm. films. It also has recently acquired a portable 70 mm. unit for use among adults. All cases which appear to be tuberculosis are followed up with roentgenologic tests and with examinations in clinics and by physicians.

Dallas has a good record as a health center, much of which can be attributed to its excellent public health program. The health department set up the first free venereal disease clinics in the South. Dallas was one of the first cities in the country to have compulsory smallpox vaccination in schools. The city has free immunization for those who cannot afford to pay. The health department has set up eighteen "health centers" throughout the city. These centers, conducted by nurses, offer "well baby conferences," supervision for preschool children, lectures, immunization, infant care and home visits, and follow-up work with children who have been in hospitals. There is also the Dallas Day Nursery and Infant Welfare Association, a Community Chest agency, which works along the same lines as the health centers.

A home delivery service for expectant mothers has been established to help alleviate the hospital bed shortage. This service is in cooperation with Southwestern Medical Foundation and the City-County Hospital, and is for women who have had at least one child and had no trouble in delivering it. Visiting Nurses, sponsored by the Community Chest, are for maternity cases, for the acutely ill, and for the chronically ill.

The Dallas County Medical Society is currently conducting a broad program of health education in the public schools of Dallas. This is believed to be the only such medical society plan in the nation. More than 100 doctors are taking part in scheduled medical talks in the city high schools, and all members of the Society are taking at least indirect parts in the project. Plans call for five major subjects to be discussed: surgery, pediatrics, medicine, gynecology and urology.

The Dallas County Medical Society has established a Dallas County Medical Plan to provide prepaid medical care for people in the low income brackets at only a few cents a day.

In addition to the Southwestern Medical Foundation and hospital expansion projects for the near future, plans are also being made for enlarging the Medical Arts Building by 60 per cent. A third addition of eighteen stories to the present structure is contemplated as soon as construction materials are available.

Dallas, in addition to being a great medical center of the Southwest, is also a center of trade, commerce, industry, and culture.

Dallas has an annual Metropolitan Opera season, and the Dallas Symphony Orchestra is recognized internationally as a leading organization. There are 54 motion picture theaters in the city and 55 night clubs. White Rock Lake, in the suburbs of Dallas, attracts over a million visitors each summer. There are 68 parks, a dozen fine golf courses, a score of swimming pools, tennis courts, bridle paths, and community houses for picnics.

Dallas has the largest State Fair in the country. On the Fair grounds are the $5,000,000 Civic Center, Cotton Bowl, and Health Museum. The Health Museum, of especial interest to visiting doctors, was established by the Dallas Academy of Medicine to tell the story of health to the citizenry at large of Dallas and the Southwest. The Civic Center includes an Art Museum with a $2,000,000 collection; an Aquarium; a Band

Shell and Amphitheater, home of the summer Starlight Operettas; a Museum of Natural History; and the Hall of State, housing the priceless collection of the Dallas Historical Society. Dallas is host city each New Year's Day for the annual Cotton Bowl classic in football, at which time the outstanding teams of the Southwest are pitted against teams from all sections of the country.

Greater Dallas has 84 schools, of which 10 are senior high schools. Southern Methodist University, which first opened its doors to 706 students in 1915, now has an enrollment in excess of 6,600. The Dallas Manufacturers' and Wholesalers' Association is currently sponsoring a school of design at Southern Methodist University in view of the increasing prestige of Dallas as a center of distinctive styling for women's fashions.

Banking in the Southwest is centered in Dallas, the home of the Federal Reserve Bank for the Eleventh District, serving Texas, parts of Louisiana, Oklahoma, New Mexico, and Arizona. The city is the home of eight national banks and eleven state banks. Two of the city's banks are among the first one hundred banks in the nation in volume of business.

Dallas is first of all cities in the Southwest in retail sales, wholesale sales, number of manufacturing plants, value of industrial production, banking volume, insurance, communications, and many other fields.

Historically, Dallas was born as a log cabin trading post built by John Neely Bryan on the banks of the Trinity River, in 1841. Today, a replica of that log cabin has been erected on the courthouse lawn, in the shadows of towering skyscrapers of the financial and commercial houses in Dallas.

Truly, Dallas is "The City of Opportunity," and one of the really great medical centers of the country, one that is becoming greater each year. The cooperation and coordination of the various city and county hospitals, social agencies, and health departments, have produced a unified front which ranks high in the medical field, and Dallas physicians and dentists are recognized throughout the world as great leaders and scientists.

MONDAY, MAY 5	TUESDAY, MAY 6	WEDNESDAY, MAY 7	THURSDAY, MAY 8
REGISTRATION AND SPECIAL SOCIETIES TEXAS RY. & TRAUMATIC SURGICAL ASSOCIATION TEXAS STATE HEART ASSOC. TEXAS NEUROPSYCHIATRIC ASSOC. TEXAS SOC. OF GASTROENTEROLOGISTS & PROCTOLOGISTS TEXAS ASSOC. OF MED. ANESTHETISTS TEXAS CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS CONFERENCE, CITY AND COUNTY HEALTH OFFICERS	8:00 A. M. REGISTRATION Visit Technical and Scientific Exhibits 9:00 A. M.—10:00 A. M. OPENING EXERCISES Visit Technical and Scientific Exhibits 10:15 A. M.—12:15 P. M. GENERAL MEETING 1:30 P. M.—5:30 P. M. SECTION MEETINGS (8 SECTIONS) Visit Technical and Scientific Exhibits 6:00 P. M.—8:30 P. M. ALUMNI BANQUETS SPECIAL GROUPS 7:00 P. M.—9:00 P. M. HOUSE OF DELEGATES 9:15 P. M. PRESIDENTS RECEPTION AND BALL	8:00 A. M.—12:00 NOON HOUSE OF DELEGATES 8:00 A. M.—12:00 NOON SECTION MEETINGS (8 SECTIONS) Visit Technical and Scientific Exhibits 12:45 P. M.—2:45 P. M. CLINICAL LUNCHEONS MEDICINE AND PEDIATRICS SURGERY, OBSTETRICS & GYNECOLOGY EYE, EAR, NOSE AND THROAT Visit Technical and Scientific Exhibits 3:00 P. M.—4:30 P. M. GENERAL MEETING 4:45 P. M.—5:45 P. M. MEMORIAL SERVICES 6:30 P. M.—7:45 P. M. FRATERNITY BANQUETS 6:30 P. M.—9:00 P. M. DALLAS COUNTY SOCIETY ENTERTAINMENT	8:00 A. M.—11:00 A. M. HOUSE OF DELEGATES ELECTION OF OFFICERS Visit Technical and Scientific Exhibits 9:30 A. M.—11:40 A. M. GENERAL MEETING Visit Technical and Scientific Exhibits 12:00 NOON—2:00 P. M. COMBINED SECTIONS LUNCHEON 2:00 P. M.—4:30 P. M. COMBINED SECTIONS MEETING
10:00 A. M.—12 NOON HOUSE OF DELEGATES Visit Technical and Scientific Exhibits 1:00 P. M. HOUSE OF DELEGATES 8:00 P. M. HOUSE OF DELEGATES			

Data Requested by Council on Scientific Work for Preparation of the 1948 Annual Session Program

Each registrant is requested to furnish the data asked for here. The information may either be turned in to the Section Officers or to the Registration Desk at the annual session, or may be mailed to the State Secretary, 1404 West El Paso Street, Fort Worth.

A. Nominate, in order of preference, your choice of out-of-state guest speakers for the 1948 annual session, indicating the specialty of each and the section before which he should appear.

B. List at least five subjects on which you would like to hear papers read.

C. Write any suggestions or criticisms you care to make concerning the conduct of, or arrangements for, the annual session.

Announcements and Program

of the

EIGHTIETH ANNUAL SESSION

of the

STATE MEDICAL ASSOCIATION OF TEXAS

DALLAS, TEXAS

ANNOUNCEMENTS

Scientific activities of the annual session will be housed in Hotel Adolphus with few exceptions. The following meetings will be held in the Baker Hotel: The Section on Surgery will meet in the Texas Room, Mezzanine Floor. The Section on Eye, Ear, Nose, and Throat will meet in Rooms 5 and 6, Mezzanine Floor. The Section on Clinical Pathology will meet Tuesday afternoon and at 11:00 a. m. Wednesday in Room 4, Mezzanine Floor (but will meet at 8:30 a. m. Wednesday for a clinical-pathological conference, in Hotel Adolphus). Two Clinical Luncheons, Surgery, Obstetrics, and Gynecology in the Lounge, and Eye, Ear, Nose, and Throat in Room 1, will be held on the Mezzanine Floor of the Baker Hotel.

The Registration Office and Information Bureau will be located on the Lobby Floor of Hotel Adolphus. Members, medical visitors, and guests should register here immediately upon arriving in the city and obtain badges and programs. Tickets and information concerning the Clinical Luncheons will be available here. Address telegrams, telephone calls, and mail to the Information Bureau, State Medical Association, Hotel Adolphus during the period of the annual session. Telephone information service will also be available here. Four direct outside lines (R-8512, R-8513, R-8514, and R-8515) will be installed, and three house telephones will also be available.

The Woman's Auxiliary will have its headquarters at the Baker Hotel, across the street from Hotel Adolphus. Courtesy and information committees from the Woman's Auxiliary to the Dallas County Medical Society will be on duty in the Adolphus and Baker Hotels. All ladies in attendance on the annual session should register at the Registration Bureau on the Mezzanine Floor of the Baker Hotel immediately upon arriving in the city.

The Committee on Hotels will establish hotel information services in connection with the Information Bureau of the State Medical Association.

The Press and Stenographers Room will be Parlor B, Sixth Floor, Hotel Adolphus.

The House of Delegates will meet in the Roof Garden, Fifteenth Floor of Hotel Adolphus. The first session will be held Monday, May 5, at 10:00 a. m. (p. 722).

The Board of Councilors will hold its meetings in Parlor C, Sixth Floor, Hotel Adolphus.

A Council on Scientific Work Breakfast for members of the permanent Council and Section Officers for the 1947 and the 1948 annual sessions will be held in Parlor E, Sixth Floor, Hotel Adolphus, at 7:30 a. m., Tuesday, May 6, with the State Medical Association as host.

The Past-Presidents' Association will meet for luncheon in Room 434, Fourth Floor, Baker Hotel, at 12:30 p. m., Tuesday, May 6. Dr. L. H. Reeves, Fort Worth, is secretary of the Association.

The Opening Exercises will be held in the Ballroom of Hotel Adolphus at 9:00 a. m., Tuesday, May 6 (p. 703).

The Memorial Services will be held in the Ballroom of Hotel Adolphus from 4:45 to 5:45 p. m., Wednesday, May 7 (p. 704).

The President's Reception and Ball will be held in the Crystal Ballroom, Mezzanine Floor, Baker Hotel, Tuesday, May 6, at 9:15 p. m. All members of the Association, guests, and visitors are invited.

The Clinical Luncheons will be held from 12:45 to 2:45 p. m., Wednesday, May 7, and from 12:00 noon to 2:00 p. m., Thursday, May 8. There will be three sectional luncheons on Wednesday, namely, Medicine and Pediatrics; Surgery, Obstetrics, and Gynecology, and Eye, Ear, Nose, and Throat. There will be only one Clinical Luncheon on Thursday, the Combined Sections Luncheon. Tickets for the luncheons may be obtained from the Information Bureau. The cost of tickets to a luncheon will be $1.75.

Luncheon tickets will be on sale only at the time of registration, and will be required for admittance to the luncheons. If circumstances prevent a registrant from attending a luncheon for which he has bought a ticket, refund of the purchase price in full will be made at the Information Bureau up to 6:00 p. m. of the day preceding the luncheon; no refund will be made after that hour. No tickets will be sold for a luncheon after 10:30 a. m. on the day of the luncheon.

The Medicine and Pediatrics Luncheon, Wednesday, will be held in the Roof Garden and North Room, Fifteenth Floor, Hotel Adolphus (p. 706).

The Surgery, Obstetrics, and Gynecology Luncheon, Wednesday, will be held in the Lounge, Mezzanine Floor, Baker Hotel (p. 706).

The Eye, Ear, Nose, and Throat Luncheon, Wednesday, will be held in Room 1, Mezzanine Floor Baker Hotel (p. 706).

The Combined Sections Luncheon, Thursday, will be held in the Roof Garden and North Room, Fifteenth Floor, Hotel Adolphus (p. 706).

A Dallas County Medical Society Buffet Supper and Dance for members of the Association, guests, and visitors will be held from 6:30 to 9:00 p. m., Wednesday, May 7, at the Plantation, 6400 Harry Hines Boulevard.

Alumni Banquets will be held from 6:00 to 8:30 p. m., Tuesday, May 6.

The University of Texas Medical Branch Alumni Banquet will be held in the Palm Garden, Twenty-First Floor, Hotel Adolphus, on Tuesday, May 6, at 6:00 p. m. Dr. Chauncey D. Leake, vice-president and dean of the Medical Branch, will speak. Tickets will be available from the Secretary-Treasurer, in Dallas, beginning May 5. Reservations may be made in advance by writing Miss Mildred M. Robertson, Alumni Association Medical Branch, Galveston.

Fraternity Banquets will be held from 6:30 p. m. to 7:45 p. m. on Wednesday, May 7.

Dr. Tate Miller, Medical Arts Building, Dallas, chairman of the committee on alumni banquets, will be glad to assist with arrangements for any alumni or fraternity group desiring to hold a banquet.

Golf.—The Annual State Medical Association Golf Tournament will be held at the Dallas Country Club. Additional information will be available at the Information Bureau of the State Medical Association, Lobby Floor, Hotel Adolphus, or from Dr. H. A. O'Brien, Medical Arts Building, Dallas, chairman of the committee on golf.

Skeet and Trap Shoot.—A skeet and trap shoot for members of the State Medical Association will be held at the Dallas Gun Club on Wednesday, May 7, beginning at 1:00 p. m. The Stuart Adams Trophy, a silver cup donated in 1939 by the Bexar County Medical Society, to go to the year's high over-all marksman and to be retained permanently by a marksman only after he has won it three successive years, will be awarded to the physician

making the best score out of a 100-bird shot at either skeet or trap. Full information will be available at the Information Bureau of the State Medical Association, Lobby Floor, Hotel Adolphus, or from Dr. Arthur G. Schoch, Medical Arts Building, Dallas, chairman of the skeet and trap shoot.

SCIENTIFIC SECTIONS

The places of meeting of the scientific sections will be as follows:

Section on Medicine, Ballroom, Lobby Floor, Hotel Adolphus (p. 706).

Section on Surgery, Texas Room, Mezzanine Floor, Baker Hotel (p. 708).

Section on Obstetrics and Gynecology, Danish Room, Fifteenth Floor, Hotel Adolphus (p. 710).

Section on Eye, Ear, Nose, and Throat, Rooms 5 and 6, Mezzanine Floor, Baker Hotel (p. 711).

Section on Radiology and Physiotherapy, Parlor F, Sixth Floor, Hotel Adolphus (p. 712).

Section on Public Health, North Room, Fifteenth Floor, Hotel Adolphus (p. 713).

Section on Clinical Pathology, Room 4, Mezzanine Floor, Baker Hotel, Tuesday afternoon, May 6, and at 11:00 a. m. Wednesday, May 7; Palm Garden, Twenty-First Floor, Hotel Adolphus, at 8:30 a. m., Wednesday, May 7 (p. 715).

Section on Pediatrics, Parlor E. Sixth Floor, Hotel Adolphus (p. 715).

HOTELS AND TOURIST COURTS

Dallas Hotels

Hotel	*Rates*
Adolphus	Double, $2.50-$7.00
Baker	Double, $2.50 up
Clifton	Double, $2.75
Jefferson	$1.50 up
Lakewood	Single, $3.50-$4.00 Double, $5.00-$6.00
Lawn	Single, $3.50-$4.00 Double, $5.00-$6.00
Lomo Alto	Single, $3.50-$4.00 Double, $5.00-$6.00
Mayfair	$2.00 up
Melrose	$3.00-$5.00
Southland	$2.00 up
Stoneleigh	Single, from $3.50 Double, from $4.50
White-Plaza	Double, $3.50-$7.50
Whitmore	Single, from $2.00 Double, from $4.00

Dallas Tourist Courts

Court	*Rates*
Grande Lodge	Single, $2.50 Double, $4.00-$5.00
Motor Inn Hotel	Double, $2.50-$3.50 Connecting rooms up to 5 persons, $5.00-$6.00
Tower Hotel Courts	Single, $4.00 Double, $5.00 Twin beds, $6.00
Town House Tourist Courts	Double, $6.00 Twin beds, $7.00

GENERAL MEETINGS

OPENING EXERCISES

Tuesday, May 6

9:00 a. m. to 10:00 a. m.

Ballroom, Lobby Floor, Hotel Adolphus

Frank A. Selecman, M. D., Chairman, General Arrangements Committee, Dallas, Presiding.

1. (9:00) *Invocation.*
   Rev. Marshall T. Steele, Pastor, Highland Park Methodist Church, Dallas.
2. (9:05) *Address of Welcome.*
   John G. Young, M. D., President, Dallas County Medical Society.
3. (9:20) *Greetings from the Woman's Auxiliary to the State Medical Association of Texas.*

Mrs. George Turner, El Paso, President, Woman's Auxiliary to the State Medical Association of Texas.

4. (9:30) *President's Address: Our Changing Methods.*

Claude C. Cody, Jr., M. D., Houston, Eighty-First President, State Medical Association of Texas.

Ten minute recess.

GENERAL MEETING

Tuesday, May 6

10:15 a. m. to 12:15 p. m.

Ballroom, Lobby Floor, Hotel Adolphus

Claude C. Cody, Jr., M. D., President, Presiding

1. (10:15 a. m.) *The Early Diagnosis of Cancer of the Uterus.*

Harold O. Jones, M. D., F. A. C. S.
Chicago, Ill.
(Guest of the Section on Obstetrics and Gynecology.)
Professor of Gynecology, Northwestern University; Chairman of Obstetrics and Gynecology, St. Luke's Hospital.

A review of the methods of treatment is presented to emphasize the small percentage of salvage in this disease. The various diagnostic methods are discussed and a plan is suggested to facilitate the accurate interpretations of biopsy specimens. The influence of the estrogens on these tissues is illustrated with case histories. Integration of lay propaganda with accurate medical diagnostic procedures is discussed.

2. (10:45 a. m.) *Serodiagnosis in Syphilis.*

R. H. Kampmeier, M. D., F. A. C. P.,
Nashville, Tenn.
(Guest of the Section on Medicine.)
Associate Professor of Medicine, Vanderbilt University School of Medicine.

For the physician probably the most difficult problem in the field of syphilis is the interpretation of the results of serologic tests. In the presence of syphilis the blood tests may be negative, doubtful, or positive. The same sample of blood may give different results with the several different tests in use. Because of the frequency with which blood tests are being done at the present time, physicians will encounter an increasing number of falsely positive tests. Some of these will be false biologic tests in normal persons. A greater number will represent falsely positive tests resulting from diseases other than syphilis.

3. (11:15 a. m.) *Hospital Consultations in Otolaryngology.*

John J. Shea, M. A., M. D., F. A. C. S.,
Memphis, Tenn.
(Guest of the Section on Eye, Ear, Nose, and Throat.)
Member, American Board of Otolaryngology.

A good consultation may be only a sincere solace. The physician desiring a consultation should review his case and obtain all the tests he would desire if he were to be the consultant. The otolaryngologist is available and of service for those conditions bordering upon his specialty. The paper will consider instances of cerebrospinal rhinorrhea, compound facial injury, nasal polyps, tumors during pregnancy, and the blood dyscrasias of childhood.

4. (11:45 a. m.) *Thoracic Surgery: Its Present Scope.*

Herbert D. Adams, M. D., F. A. C. S.,
Boston, Mass.
(Guest of the Section on Surgery.)
General and Thoracic Surgeon, Lahey Clinic, New England Baptist Hospital, and New England Deaconess Hospital; Reserve Consultant in Thoracic Surgery; U. S. Naval Hospital, Chelsea, Mass.

Our present concepts and management of surgical lesions within the thorax have changed radically since the advent of chemotherapy. War casualties have brought further developments—more conservative management in some respects and more radical management in others. The surgery of many important intrathoracic lesions is now highly standardized and can be carried out with great safety and good results. Consideration will be given to the following: (1) trauma—management of hemothorax and its sequelae, crushed chest, diaphragmatic hernia; (2) intrathoracic infection—empyema, bronchiectasis (lobectomy and segmental pneumonectomy), tuberculosis (present status of pulmonary resection), lung abscess, subdiaphragmatic abscess, mediastinitis; (3) tumors—benign intrathoracic tumors, bronchiogenic carcinoma, diagnosis and treatment; (4) surgery of the esophagus—obstructing lesions, diverticula, esophagitis, benign tumors, carcinoma; (5) heart—pericarditis, anomalies, patent ductus arteriosus, coarctation of the aorta, pulmonary stenosis.

GENERAL MEETING

Wednesday, May 7
3:00 p. m. to 4:30 p. m.
Ballroom, Lobby Floor, Hotel Adolphus
Claude C. Cody, Jr., M. D., President, Presiding

1. (3:00 p. m.) *Some Problems in the Field of Medical Economics.*

Harrison H. Shoulders, M. D.,
Nashville, Tenn.
(Guest of the State Medical Association.)
President, American Medical Association.

Regardless of the advancement that has been made here and there in the field of medical economics, the subject is not thoroughly understood by many members of the profession who are not in position of leadership, and yet their cooperation is vitally essential. A brief discussion of the broad subject, "economics," will be given first. Then there will be a consideration of what is embraced in medical economics, the income of the people, the application of the insurance principle to the financing of medical care, and the preservation of freedom in medicine.

2. (3:30 p. m.) *Treatment of Peptic Ulcer.*

Walter L. Palmer, Ph. D., M. D.,
Chicago, Ill.
(Guest of the Section on Medicine.)
Professor of Medicine, University of Chicago.

The diagnosis, etiology, role of nervous factors, and methods of treatment will be discussed.

3. (4:00 p. m.) *The Incorporation of Preventive Medicine in Clinical Practice.*

Wilson G. Smillie, M. D.,
New York, N. Y.
(Guest of the Section on Public Health.)
Professor of Public Health and Preventive Medicine, Cornell University Medical College.

A distinction is made between "public health," which is the responsibility of the community, and "preventive medicine," which is the responsibility of the practitioner of medicine. The necessity for the incorporation of preventive medicine in clinical practice is emphasized, and suggestions are presented whereby this desideratum may be achieved.

MEMORIAL SERVICES

Wednesday, May 7
4:45 p. m. to 5:45 p. m.
Ballroom, Lobby Floor, Hotel Adolphus
M. D. Levy, M. D., Houston, Chairman, Committee on Memorial Exercises, Presiding

1. *Invocation.* REV. ROBERT GOODRICH, Pastor, First Methodist Church, Dallas.
2. *Adagio from Sonata in D Minor.* Brahms. MRS. PENN RIDDLE, Dallas, Violinist. MRS. HARRY M. CRENSHAW, Dallas, Accompanist.
3. *Roll Call of Deceased Members and Memorial Address for Woman's Auxiliary.* MRS. W. R. THOMPSON, Fort Worth.
4. *Roll Call of Deceased Physicians.* HOLMAN TAYLOR, M. D., Secretary, State Medical Association, Fort Worth.
5. *Memorial Address for Physicians.* M. D. LEVY, M. D., Houston.
6. *Jesus Savior Pilot Me.* MALE QUARTET, First Baptist Church, Dallas.
7. *Benediction.* REV. ROBERT GOODRICH.

GENERAL MEETING

Thursday, May 8

9:30 a. m. to 11:40 a. m.

Ballroom, Lobby Floor, Hotel Adolphus

CLAUDE C. CODY, JR., M. D., President, Presiding

1. (9:30 a. m.) *The Problem of Exotic Diseases.*

THOMAS B. MAGATH, Ph. D., M. D., F. A. C. P., Rochester, Minn.

(Guest of the Section on Clinical Pathology.)

Chief, Division of Clinical Laboratories, Mayo Clinic, and Professor of Pathology and Parasitology, Mayo Foundation. University of Minnesota.

The past war focused sharp attention on diseases of international interest and the possibility of foreign diseases being introduced into this and other countries. It was believed by many that the scattering of large numbers of troops in foreign lands, especially in the tropics, would be hazardous to the health of the United States and that both tropical diseases and their vectors would become implanted on these shores. This thesis will be examined from the standpoint of what actually happened and what may be expected in the future from exposures during the war and those which are likely to follow an expanding trade based on rapid transportation.

2. (10:00 a. m.) *Tuberculosis in Infants and Children.*

WALDO E. NELSON, M. A., M. D., Philadelphia, Pa.

(Guest of the Section on Pediatrics.)

Professor of Pediatrics, Temple University Medical School.

It will be emphasized that tuberculosis still exists as a major cause of death among infants and children and that its control is dependent upon the detection and segregation of all openly active cases irrespective of the age of the patient. The diagnosis of tuberculosis in children may be suspected from the history, physical examination, and/or roentgenographic film; however, the tuberculin test and bacteriologic examinations are of the greatest moment. Cases of tuberculosis and of other clinical conditions simulating tuberculosis will be presented to illustrate the problems of differential diagnosis. The importance of considering the tuberculous child's family as a unit in relation to the source of the infection and the future management of the case will be stressed. The use of the small film (photofluorographic film) and of certain fungous antigen tests in addition to the tuberculin test in community surveys as well as in the evaluation of the individual patient and his family will also be discussed.

3. (10:30 a. m.) *Preoperative and Postoperative Supportive Therapy in Gastro-Intestinal Surgery.*

JOSEPH M. DONALD, M. S., M. D., F. A. C. S., Birmingham, Ala.

(Guest of the Section on Surgery.)

Assistant Professor of Surgery, Medical College of Alabama.

Preoperative and postoperative therapy is now recognized more than ever before as a major factor in rendering the patient safe for surgery. There are very few surgical emergencies in which preoperative preparation cannot be carried out. The present methods of proved value in the preparation of patients for surgery of the gastro-intestinal tract are discussed, including decompression, water and electrolyte balance, blood transfusion, and chemotherapy. The importance of having the patient in the proper frame of mind for operation is emphasized. The prevention and treatment of certain postoperative complications will be discussed, including abdominal distention, pulmonary complications, thrombophlebitis, wound disruption, and peritonitis. Experiences with early ambulation will be reviewed.

4. (11:00 a. m.) *The Roentgenologic Contribution to the Diagnosis of Colitis and Enteritis.*

HARRY M. WEBER, M. D., Rochester, Minn.

(Guest of the Section on Radiology and Physiotherapy.)

Associate Roentgenologist, Section on Roentgenology, Mayo Clinic; Assistant Professor of Radiology, Mayo Foundation, University of Minnesota.

As used in this discussion the terms "colitis" and "enteritis" refer to intestinal diseases characterized by genuine inflammatory change in the wall of the intestine and in its mucous membrane. Several known and some unknown etiologic factors contribute to the pathogenesis of these diseases. The roentgenologic manifestations accurately reflect the character and extent of the pathologic change which has taken place in the intestine. The value of the roentgenologic examination of the intestine depends on this fact. The basis for a classification of the more frequently encountered varieties of chronic colitis and enteritis will be discussed. The roentgenologic manifestations will be shown by lantern slides of typical examples. Particular emphasis will be placed on the usefulness of the roentgenologic method in establishing the diagnosis of colitis and enteritis and in distinguishing true colitis and enteritis from the spurious.

5. (11:30 a. m.) *Some Aspects of Naval Medical Research in Wartime.*

WILLIAM L. MANN, Ph. B., A. M., M. D., F. A. C. S., Rear Admiral, M. C., U. S. N. (Ret). Georgetown, Texas.

(Guest of the State Medical Association.)

First Commanding Officer, Naval Medical Research Institute; Ex-President, Association of Military Surgeons; formerly Force Surgeon, Fleet Marine Force.

Modern naval warfare—on land, in the air, on sea, and under the sea—creates extremes of environmental conditions that re-

quire careful study and research by the Naval Medical Department. Many of the wartime problems have no counterpart in times of peace. The Naval Medical Research Institute was planned primarily to study the urgent medical problems of wartime. One of the early successful projects of this activity was a method of making drinking water from sea water. War has been defined as an "epidemic of trauma," and it seems only fitting that medical departments of the military services initiate research and study to cope with this type of epidemic.

COMBINED SECTIONS MEETING

Thursday, May 8

2:00 p. m. to 4:30 p. m.

Roof Garden and North Room, Fifteenth Floor, Hotel Adolphus

CLAUDE C. CODY, JR., M. D., President, Presiding

1. (2:00 p. m.) *Parenteral Fluid Therapy of Infants.*
   WALDO E. NELSON, Philadelphia, Pa.
2. (2:15 p. m.) *The Roentgenologic Examination in the Diagnosis of Functional Intestinal Abnormality.*
   HARRY M. WEBER, Rochester, Minn.
3. (2:30 p. m.) *The Management of Acute Cholecystitis.*
   JOSEPH M. DONALD, Birmingham, Ala.
4. (2:45 p. m.) *Functional Disturbances of the Digestive Tract.*
   WALTER L. PALMER, Chicago, Ill.
5. (3:00 p. m.) *Present Status of Thyroid Surgery.*
   HERBERT D. ADAMS, Boston, Mass.
6. (3:15 p. m.) *Therapeutic Agents of Value in the Management of the Menopause.*
   HAROLD O. JONES, Chicago, Ill.
7. (3:30 p. m.) *The Diagnosis of Neurosyphilis.*
   R. H. KAMPMEIER, Nashville, Tenn.
8. (3:45 p. m.) *The Therapy of Headache.*
   JOHN J. SHEA, Memphis, Tenn.
9. (4:00 p. m.) *Laboratory Tests for Blood Coagulation Factors.*
   THOMAS B. MAGATH, Rochester, Minn.
10. (4:15 p. m.) *The Place of Geriatrics in the General Practice of Medicine.*
    WILSON G. SMILLIE, New York, N. Y.

CLINICAL LUNCHEONS

MEDICINE AND PEDIATRICS

Wednesday, May 7

12:45 p. m. to 2:45 p. m.

Roof Garden and North Room, Fifteenth Floor, Hotel Adolphus

ELLIOTT MENDENHALL, M. D., Dallas, Presiding

HONOR GUESTS

R. H. KAMPMEIER, Nashville, Tenn., Guest of the Section on Medicine.

WALDO E. NELSON, Philadelphia, Pa., Guest of the Section on Pediatrics.

WALTER L. PALMER, Chicago, Ill., Guest of the Section on Medicine.

WILSON G. SMILLIE, New York, N. Y., Guest of the Section on Public Health.

HARRY M. WEBER, Rochester Minn., Guest of the Section on Radiology and Physiotherapy.

EYE, EAR, NOSE, AND THROAT

Wednesday, May 7

12:45 p. m. to 2:45 p. m.

Room 1, Mezzanine Floor, Baker Hotel

KELLY COX, M. D., Dallas, Presiding

HONOR GUEST

JOHN J. SHEA, Memphis, Tenn., Guest of the Section on Eye, Ear, Nose, and Throat.

SURGERY, OBSTETRICS, AND GYNECOLOGY

Wednesday, May 7

12:45 p. m. to 2:45 p. m.

Lounge, Mezzanine Floor, Baker Hotel

B. E. PARK, M. D., Dallas, Presiding

HONOR GUESTS

HERBERT D. ADAMS, Boston, Mass., Guest of the Section on Surgery.

JOSEPH M. DONALD, Birmingham, Ala., Guest of the Section on Surgery.

HAROLD O. JONES, Chicago, Ill., Guest of the Section on Obstetrics and Gynecology.

THOMAS B. MAGATH, Rochester, Minn., Guest of the Section on Clinical Pathology.

HARRISON H. SHOULDERS, Nashville, Tenn., Guest of the State Medical Association.

COMBINED SECTIONS LUNCHEON

Thursday, May 8

12:00 noon to 2:00 p. m.

Roof Garden and North Room, Fifteenth Floor, Hotel Adolphus

EDWARD WHITE, M. D., Dallas, Presiding

HONOR GUESTS

HERBERT D. ADAMS, Boston, Mass., Guest of the Section on Surgery.

JOSEPH M. DONALD, Birmingham, Ala., Guest of the Section on Surgery.

HAROLD O. JONES, Chicago, Ill., Guest of the Section on Obstetrics and Gynecology.

R. H. KAMPMEIER, Nashville, Tenn., Guest of the Section on Medicine.

THOMAS B. MAGATH, Rochester, Minn., Guest of the Section on Clinical Pathology.

WALDO E. NELSON, Philadelphia, Pa., Guest of the Section on Pediatrics.

WALTER L. PALMER, Chicago, Ill., Guest of the Section on Medicine.

JOHN J. SHEA, Memphis, Tenn., Guest of the Section on Eye, Ear, Nose, and Throat.

WILSON G. SMILLIE, New York, N. Y., Guest of the Section on Public Health.

HARRY M. WEBER, Rochester, Minn., Guest of the Section on Radiology and Physiotherapy.

SECTION MEETINGS

SECTION ON MEDICINE

Tuesday, May 6

1:30 p. m. to 5:30 p. m.

Ballroom, Lobby Floor, Hotel Adolphus

Chairman—JAMES A. GREENE, Houston.

Secretary—RAYMOND GREGORY, Galveston.

Guests of the Section—R. H. KAMPMEIER, Nashville, Tenn., and WALTER L. PALMER, Chicago, Ill.

Guest Sponsors—HENRY WINANS, Dallas (Dr. Kampmeier), and SAMUEL A. SHELBURNE, Dallas. (Dr. Palmer).

1. (1:30) *Allergy of Gastro-Enteric Tract.*
GEORGE J. SEIBOLD, Houston.

The incidence of manifestations and the differential diagnosis of gastro-enteric allergy will be presented. Etiologic factors, histopathology, evaluation of diagnostic procedures, diagnosis, and treatment will be discussed.

Discussion to be opened by CHARLES B. SHUEY, Dallas.

2. (2:00) *Diverticulosis and Divertieulitis.*
J. T. BOYD, Jacksonville.

The discussion deals primarily with the acquired diverticula, and attempts to correlate the most commonly accepted beliefs as to incidence and etiology. The symptoms and signs are discussed in relation to the pathologic changes. The problems most often encountered in differential diagnosis are considered. The treatment of diverticulitis is presented in the belief that medical and surgical coöperative measures are necessary. The mortality rate will serve as a basic index of this coöperation.

Discussion to be opened by G. E. BRERETON, Dallas; G. V. BRINDLEY, Temple; and JOHN S. BAGWELL, Dallas.

3. (2:30) *Chronic Nonspecific Ulcerative Colitis.*

WALTER L. PALMER, Ph. D., M. D., Chicago, Ill.
Professor of Medicine, University of Chicago.

Symptoms, diagnosis, and complications will be discussed briefly. Particular consideration will be given to the treatment, emphasizing the role of blood transfusions, rest, diet, psychotherapy, and chemotherapy.

4. (3:00) *Symptoms of Coronary Artery Disease Masquerading As Those of the Gastro-Enteric Tract.*
ROSS W. RISSLER, El Paso.

Angina is frequently mistaken for gastro-enteric symptoms. A careful history is one of the most important points in the differential diagnosis. Illustrative cases will be presented and the importance of a careful history stressed. Contributing factors and the nature of the disorder are emphasized.

Discussion to be opened by RALPH H. HOMAN, El Paso.

5. (3:30) *Newer Concepts of Schizophrenia.*
JACK R. EWALT, Galveston.

Schizophrenia is thought to be a group of disorders of similar symptomatology. One group includes schizophrenic reactors and another group the typical chronic deteriorative type. Patients in the second group are refractory to therapy, but temporary remissions may appear. They are considered to have physiologic or chemical alterations in addition to psychologic difficulties. The available data suggesting basic physiologic imbalance will be discussed, and some experiments conducted along these lines will be presented.

Discussion to be opened by STEPHEN WEISZ, Dallas; P. C. TALKINGTON, Dallas; and A. HAUSER, Houston.

6. (4:00) *The Use of Hydantoin (Mezantoin) As an Anticonvulsive Drug.*
TITUS HARRIS, Galveston.

Classification of the various types of epileptic convulsive attacks will be discussed, and the history of hydantoin and its clinical use in psychomotor convulsive attacks will be discussed. The author's experience with this drug will be given. It is a valuable addition to the list of anticonvulsive drugs.

Discussion to be opened by M. L. TOWLER and JOHN L. OTTO, Galveston.

7. (4:30) *Clinical Value and Limitations of Electro-Encephalography.*
M. L. TOWLER, Galveston.

Clinical application during recent years has served to establish electro-encephalography as a definite adjunct to the diagnosis of neurologic and neurosurgical problems. Since most intracranial lesions or disturbances manifest themselves by changes in electro-cortical rhythm, earlier and more accurate diagnosis and management of brain disease or disrhythmia has been made possible by electro-encephalography. Like all other laboratory procedures, electro-encephalography has its limitations and cannot replace sound clinical judgment. Brief case histories and sample tracings will be presented.

Discussion to be opened by WILLIAM MCKINNEY and MILTON FINNEY, Houston.

8. (5:00) *Diagnosis and Management of Gout.*
J. W. MIDDLETON, Galveston.

Present concepts of the diagnosis and management of gout as gained from a review of the literature and observation of cases. The incidence, clinical picture, laboratory findings, unusual manifestations, and therapy with drugs and diet are emphasized.

Discussion to be opened by RAYMOND GREGORY, Galveston, and H. T. ENGLEHARDT, Houston.

Wednesday, May 7
8:00 a. m. to 12:00 noon
Ballroom, Lobby Floor, Hotel Adolphus

9. (8:00) *Practical Value of Retinal Examination in Patients with Hypertension.*
SAMUEL A. SHELBURNE, Dallas.

A discussion of the changes in the retinal vessels that occur in various types of hypertension, with lantern slides showing these changes. The usefulness of the finding of such changes in the prognosis of hypertension and in the differential diagnosis from other conditions associated with elevations of the blood pressure is brought out.

Discussion to be opened by HOWARD E. HEYER, Dallas.

10. (8:30) *Use of Special Diagnostic Procedures in Cardiac Evaluation.*
CARL F. SHAFFER, Houston.

The solution of a diagnostic problem is fundamentally through a careful history and a complete physical examination. When should the physician use special procedures in the diagnosis of cardiac disease? Electrocardiography is discussed, with emphasis on coronary artery disease. Roentgenography is discussed, with emphasis on fluoroscopy as an aid to interpretation of murmurs. The angiocardiogram and venous cardiac catheterization are described in relation to their aid in the diagnosis of congenital heart disease before surgical intervention. Other special procedures include measurements of venous pressure, estimation of circulation time, and determination of vital capacity. The value of these methods is discussed.

Discussion to be opened by GEORGE W. PARSON, Texarkana, and E. GHENT GRAVES, Houston.

11. (9:00) *The Carotid Sinus Syndrome: Its Importance in Clinical Medicine.*
R. LOUIS COPE, H. T. ENGLEHARDT, and V. C. BAIRD, Houston.

There are few experiences in clinical practice which are more dramatic than those which result from stimulation of the sensitive carotid sinus. As the knowledge of this syndrome, once thought to be rare, becomes more widely disseminated, cases are being diagnosed more frequently. The authors have reviewed the problem, and will report on their group of cases, classifying them as cerebral, cardiac, or peripheral. Lantern slides demonstrating these varieties will be shown. The anatomic and physiologic bases of these phenomena will be outlined, and the therapeutic approach to each variety discussed.

Discussion to be opened by M. M. MINTER, San Antonio, and PAUL J. THOMAS, Dallas.

12. (9:30) *Selection of Hypertensive Patients for Sympathectomy.*
WILLIAM C. DINE, Amarillo.

Careful selection of hypertensive patients for sympathectomy is important. The underlying fundamental principles will be outlined. The method of selecting patients for such therapy and the results to be expected will be presented.

Discussion to be opened by W. B. WHITING, Wichita Falls, and MERRITT B. WHITTEN, Dallas.

13. (10:00) *Comparative Study of Drug Therapy of Essential Hypertension.*
ARTHUR RUSKIN, Galveston, and W. FRANK MCKINLEY, Marlin.

The effect of six different kinds of drugs are reported. Two methods of estimating the effect upon the pressures are presented, and the doses of the various drugs and results obtained are discussed.

Discussion to be opened by ARTHUR GROLLMAN, Dallas, and RAYMOND GREGORY, Galveston.

14. (10:30) *Cardiovascular Syphilis.*

R. H. KAMPMEIER, M. D., F. A. C. P.,
Nashville, Tenn.
Associate Professor of Medicine, Vanderbilt University School of Medicine.

Diffuse or localized myocarditis of syphilitic origin is a clinical rarity. Aortitis is the fundamental lesion in cardiovascular syphilis. This process may extend to cause aortic insufficiency, aneurysm, or narrowing of the coronary ostia. Aortitis uncomplicated by these manifestations is difficult or practically impossible of diagnosis since it adds no burden to the circulation and in general is symptomless. On the other hand the diagnosis of the most common complication, aortic insufficiency, is usually not difficult. The same is true of aortic aneurysm if it is suspected. Since the anatomic changes of the complications of aortitis are irreversible, treatment is essentially that of prevention. This means the adequate treatment of early syphilis.

15. (11:00) *Advances in the Treatment of Leukemia and Lymphoma.*
R. A. HETTIG, Houston.

Clinical experience with radioactive phosphorus has demonstrated its usefulness as a simple means of effecting internal irradiation, particularly in leukemia. It may produce remissions as enduring as those following other forms of radiation therapy although it is in no way curative. Radioactive phosphorus should become increasingly available to the practitioner as by-products of nuclear fission are released. Nitrogen mustard is being evaluated clinically at present by many investigators, but a final appraisal of its worth cannot be made yet. However, one of the apparent advantages of nitrogen mustard is its ability to provoke further clinical remissions in certain of the above diseases, even when these malignancies have become radiation-resistant. Illustrative cases will be briefly presented.

Discussion to be opened by WILLIAM L. MARR, Galveston, and M. D. LEVY, Houston.

16. (11:30) *Salicylate Intoxication.*
LYNN BERNARD and E. A. WILKERSON, Houston.

The widespread use of massive doses of salicylates has aroused interest in the pharmacologic actions and the toxic reaction of these compounds. Toxicity resulting from the average dose of these drugs is usually not expected, but may appear. The different types of toxic manifestations and certain metabolic alterations are discussed and an illustrative case is presented.

Discussion to be opened by LEROY B. DUGGAN, Houston, and CHARLES T. STONE, Galveston.

SECTION ON SURGERY

Tuesday, May 6

1:30 p. m. to 5:30 p. m.

Texas Room, Mezzanine Floor, Baker Hotel

Chairman—WALTER G. STUCK, San Antonio.

Secretary—CORNELIUS OLCOTT, Harlingen.

Guests of the Section—HERBERT D. ADAMS, Boston, Mass., and JOSEPH M. DONALD, Birmingham, Ala.

Guest Sponsors—J. W. DUCKETT, Dallas (Dr. Adams), and J. HOWARD SHANE, Dallas (Dr. Donald).

1. (1:30) *Some Important Considerations in the Diagnosis and Treatment of Peripheral Vascular Disease.*
HARRY E. NELSON, Dallas.

A discussion of the more important aspects of the pathologic physiology, pathology, and diagnosis as they contribute to the treatment and prognosis of peripheral vascular disease. The residuals of phlebothrombosis and thrombophlebitis are analyzed as to the problems they present and the methods of their management. Special treatment is also considered for primary vasospastic and arteriosclerotic peripheral vascular disease, as well as for Buerger's syndrome.

Discussion to be opened by JOHN WINTER, San Antonio.

2. (2:00) *Pulmonary Embolism Treated by Ligation of Superficial Femoral Veins.*
HENRY LEOPOLD, San Antonio.

A report of cases of pulmonary embolism treated by ligation of the superficial femoral veins, with a discussion of the relative merits of venous ligation in the deep femoral veins and inferior vena cava. Views on the relative merits of anticoagulant therapy versus surgical methods of treatment of phlebothrombosis. A case of paradoxical embolism is also presented.

Discussion to be opened by J. W. NIXON, San Antonio.

3. (2:30) *Surgery of the Major Blood Vessels.*

HERBERT D. ADAMS, M. D., F. A. C. S.,
Boston, Mass.
General and Thoracic Surgeon, Lahey Clinic, New England Baptist Hospital, and New England Deaconess Hospital; Reserve Consultant in Thoracic Surgery, U. S. Naval Hospital, Chelsea, Mass.

Until recently, surgery of the major blood vessels has been confined chiefly to the various indications for ligation, embolectomy, and the occasional surgical management of arterial aneurysm and arteriovenous aneurysm. Our war experience with vascular injuries has increased considerably our knowledge of and familiarity with the surgical management of lesions of the major blood vessels. Aneurysms, false aneurysms, and arteriovenous aneurysms in every major vascular trunk have repeatedly been treated successfully by surgical measures. The technical aspects of these operations are presented. At the same time great advances in this field have been made with reference to congenital anomalies of the great vessels in relation to the heart—patent ductus arteriosis, pulmonary stenosis, coarctation of the aorta. These lesions and their surgical management are discussed. Likewise, venous surgery has increased its scope with the development of operations for portal shunts and the prevention of embolism by ligation of the major venous trunks. Portocaval and splenocaval shunts are discussed, as well as venous ligation for the prevention of embolism.

4. (3:00) *Atypical Mononucleosis Simulating Acute Appendicitis.*
OCTAVIO GARCIA, McAllen.

Several cases of atypical infectious mononucleosis with abdominal symptoms resembling acute appendicitis. A brief history of infectious mononucleosis and its atypical phases; presentation of a case in detail; and a brief summary of 2 other cases. It is believed that such cases are easily recognized and that operation may be avoided if proper study is made of acute abdominal pain, particularly in children.

Discussion to be opened by W. E. WHIGHAM, McAllen.

5. (3:30) *Chairman's Address: The Army Postgraduate Surgical Training Program.*
WALTER G. STUCK, San Antonio.

The Medical Corps of the U. S. Army has established nine medical centers for postgraduate training in the surgical specialties, two of which are in Texas. By an elaborate system of teaching courses with Army personnel and civilian consultants, it is planned to expand the services until they can be approved for training by the various American Specialty Boards. This is of special interest to the young medical graduates as well as to all who are concerned with postgraduate specialty training.

Discussion to be opened by SAM SEELEY, Col., M. C., A. U. S., Chief, Surgical Section, Brooke General Hospital, Fort Sam Houston.

6. (4:00) *Surgical Treatment of Intertrochanteric Fractures of the Femur.*
FRANK C. HODGES, Abilene.

Intertrochanteric fractures of the femur present a greater problem than fractures of the neck of the femur. They are more frequent and usually occur in older persons. Internal fixation of the neck fractures is much simpler and has proved very successful. Some surgeons have been employing various means of internal fixation in intertrochanteric fractures for a number of years, but most surgeons have been slow in applying internal fixation in such cases. The procedure has now been proved to be a safe and sound method of treatment.

Discussion to be opened by FELIX BUTTE, Dallas.

7. (4:30) *Around the Clock Fractures in General Practice.*
MARION R. LAWLER, Mercedes.

The four most prevalent fractures seen by the author are of the clavicle, wrist, ankle, and the shaft of the humerus. Some peculiar incidents leading to the causation of these fractures are mentioned. No fracture is simple; however, the treatment of these commoner fractures is reduced to the simplest formula. Rather than including statistics or attempting to exhaust one type or phase of fractures, it is hoped to individualize the fractures reported.

Discussion to be opened by FRANK C. HODGES, Abilene.

8. (5:00) *The Use of Free Full-Thickness Buried Skin Graft in the Repair of Hernias.*
R. A. RICHESON, Houston.

The surgeon's primary concern while operating for a hernia is whether there will be a recurrence. The use of full-thickness skin in the repair of selected hernias has wide practical use because of its tensile strength, freedom from tendency to split, and its ready availability. Cutis vascularizes quickly, takes easily and well, and is gradually transformed by metaplasia into stout connective tissue. A preliminary report describing a new technique, not original but employed by the author, is made, suggesting the use of whole skin grafts inlaid under extreme tension and in such a fashion as to protect the posterior wall of the inguinal canal, to narrow the internal ring in inguinal hernias, and to repair anatomic defects in other types of hernias. The method described gives promise of good results and may be used in those cases in which fascia was formerly indicated, with even superior results.

Discussion to be opened by ELLIOTT HAY, Bellaire.

Wednesday, May 7

8:00 a. m. to 12:00 noon

Texas Room, Mezzanine Floor, Baker Hotel

9. (8:00) *Treatment of Undescended Testes.*
JOHN M. PACE, Dallas.

The embryological descent of the testis into the scrotum is briefly described and the possible sites of arrest mentioned. Accompanying the undescended testis is an inguinal hernia in a very high percentage of the cases. The retained testis fails to develop after the age of puberty. It does not produce spermatozoa, and the incidence of malignancy is greatly increased. Orchidopexy and repair of the coexisting hernia should be performed before the age of puberty. The Meyer-Torek and Cabot procedures are described and indications are given for each of these two methods. Illustrative cases are reported. (Lantern slides.)

Discussion to be opened by B. WEEMS TURNER, Houston.

10. (8:30) *Treatment of Renal Colic with Special Emphasis on Crystalluria.*
PAUL R. STALNAKER, Houston.

This paper emphasizes the author's latest views on the treatment of renal colic. He reports his method of treatment in more than 200 cases, emphasizing acid ash diet, medication, physical examinations, repeated clinical laboratory tests of urine, blood count, blood chemistry, the use of para-sympathetic stimulators such as neostigmin, and the withholding of opiates in any form, as they give a "false sense of security." He contends that if opiates are necessary, it is much better to perform surgery first rather than use retrograde catheterization, as the latter often further complicates and distorts the clinical picture.

Discussion to be opened by JOHN T. MOORE, Houston.

11. (9:00) *The Scalenus Anticus and Cervical Rib Syndrome.*

JOSEPH M. DONALD, M. S., M. D., F. A. C. S.
Birmingham, Ala.
Assistant Professor of Surgery, Medical College of Alabama.

The relative importance of the scalenus anticus and cervical rib in producing brachial plexus neuritis and vascular disturbance of the upper extremities is discussed. Only 10 per cent of cervical ribs produce symptoms. The incidence of scalenus anticus syndrome without the presence of a cervical rib is much greater than with the rib. Symptoms of the two syndromes are similar; however, the objective findings are usually more noticeable when associated with a cervical rib. Experiences in the management of the condition for the past ten years is reviewed. Accuracy in the diagnosis of the scalenus anticus syndrome in the absence of a cervical rib is most important, and may prove difficult at times. Scalenotomy in all cases is not indicated as many cases are mild and respond to conservative measures. Results from scalenotomy have been excellent. Occasionally it is necessary to remove the cervical rib, in addition to sectioning the muscle, for relief of symptoms.

12. (9:30) *Early Ambulation in Surgery.*
ROBERT H. BELL, Palestine.

Early ambulation promotes more rapid convalescence through faster healing of wounds by means of increased circulation and muscle activities. With its use fewer postoperative accidents such as thrombophlebitis, pulmonary embolism, ileus, and the like are observed. Earlier activity and more liberal feeding causes less abdominal distention, less pain, need for fewer narcotics, and lessened nursing care. Patients look better and have a better mental outlook. The hospital stay is lessened. Some contraindications to the use of early rising are presented, including active uncontrolled hemorrhage, thyroid crises, cardiac failures, and severe peritonitis. Alloy steel wire as a suture material is praised. A detailed plan for use of early ambulation is presented.

Discussion to be opened by JOHN V. GOODE, Dallas.

13. (10:00) *Clinical Application of Streptomycin in Infections.*
EDWIN J. PULASKI, Major, M. C., A. U. S., Chief, Surgical Research Unit, Brooke General Hospital, Fort Sam Houston.

A brief historical note concerning the discovery of streptomycin, its physical properties, and data on absorption, excretion, and distribution following parenteral and oral administration, will be presented. Also, the modes of preparation and administration of the drug, current clinical indications, and the usual dosage will be discussed. Results of therapy in approximately 1,000 assorted cases of infection treated in U. S. Army hospitals will be reviewed. Certain pertinent correlative laboratory studies will be reported.

14. (10:30) *Problem of Early Diagnosis in Carcinoma of the Stomach.*
ALBERT W. HARTMAN, San Antonio.

A review of the problems of early diagnosis of cancer of the stomach, and suggested means of attacking this problem, based primarily on a review of cases in which stomachs were resected at the Lahey Clinic from 1928 to 1938. The paper will attempt to show that the most important diagnostic aid in early cancer of the stomach is a careful roentgen examination. Such an examination, in order to improve the treatment of cancer of the stomach, will have to be done in the presence of minimal symptoms, and, therefore, many negative examinations will result. Other adjuncts in the diagnosis of cancer of the stomach are gastric analysis, which is only indicative; gastroscopic examination, which is of great value in questionable cases; and, in certain cases, exploration with frozen section of the tissue. There will then be a brief discussion of the pathology of gastric malignancy.

Discussion to be opened by JOHN S. BAGWELL, Dallas.

15. (11:00) *Factors Influencing Resection of Colon and Rectal Carcinoma.*
JAMES W. HENDRICK, Baltimore, Md.

Carcinoma of the colon and rectum is frequently encountered. Tumors of the right colon in general produce different symptoms from those of the left colon. Early diagnosis is imperative if adequate treatment is to be properly executed. Since so many of these tumors occur in an older group of people, it is necessary to pay careful attention to the blood chemistries, correct anemia if present, and administer sulfasuxidine or sulfathaladine to lessen bacteria in the colon. Continuous spinal anesthesia is the anesthetic of choice. Careful postoperative management is imperative. The operative procedure depends on the location of the tumor. It involves resection of the tumor and gland bearing area, with primary anastomosis, with the exception of the lower sigmoid and rectum, which necessitates an abdomino-perineal resection.

Discussion to be opened by HARRY BURR, Houston.

16. (11:30) *Technique of Colostomy Closures.*
FRANCIS C. USHER, Houston.

Twenty-five cases of Mikulicz type colostomies were closed by dissecting the colonic stoma free of the abdominal wall and performing an open type intraperitoneal closure. There was no mortality and only one complication, a fecal fistula, which closed spontaneously. Because of the technical ease of performing this type of closure and the adequate lumen resulting at the line of anastomosis, it is believed to have a definite advantage over the old extraperitoneal type of closure. Careful preoperative and postoperative care, employing succinylsulfathiazole, low residue diet, blood transfusion, postoperative chemotherapy, and Wangensteen suction, are necessary to eliminate the hazard of infection.

Discussion to be opened by GEORGE WALDRON, Houston.

SECTION ON OBSTETRICS AND GYNECOLOGY

Tuesday, May 6

1:30 p. m. to 5:30 p. m.

Danish Room, Fifteenth Floor, Hotel Adolphus

Chairman—G. HERBERT BEAVERS, JR., Fort Worth.
Secretary—WILLIAM P. DEVEREUX, Dallas.
Guest of the Section—HAROLD O. JONES, Chicago, Ill.
Guest Sponsor—WILLIAM F. MENGERT, Dallas.

1. (1:30) *The Persistent Positive Friedman Test in Hydatid Moles.*
MAY OWEN, Fort Worth.

The value of biological tests in the follow-up of patients after the removal of hydatid moles is discussed, and the laboratory findings in 4 cases are presented.

Discussion to be opened by W. K. STROTHER, JR., Dallas.

2. (2:00) *Management of Prolonged Labor.*
WILLIAM F. MENGERT, Dallas.

Prolonged labor is common; every practitioner meets it. When infection accompanies long labor, it is a dangerous complication for the infant and a serious one for the mother. Nevertheless, with proper conservative management, it is possible to bring both the infant and the mother through to a satisfactory termination.

Discussion to be opened by ROBERT A. JOHNSTON, Houston.

SYMPOSIUM ON THE RH FACTOR

3. (2:30) *Rh Factors and Their Relations to Obstetrics.*
S. FOSTER MOORE, JR., San Antonio.

The Rh factors are defined briefly and identified with their related symptomatology. Two cases of isoimmunization are presented, with their treatment. Methods of determining significant evidence of sensitization are mentioned and a practical plan of managing potentially and actually sensitized women during pregnancy and contemplated pregnancy is outlined.

4. (2:50) *Routine Rh Typing in Obstetrics.*
JESSEN L. STOWE, El Paso.

An evaluation in midpassage of the routine typing for the Rh factor in the private practice of obstetrics. An analysis of 400 consecutive deliveries in which Rh determination was performed.

5. (3:10) *Rh Antigens and Antibodies.*
JOSEPH M. HILL, Dallas.

The immunologic basis for Rh typing is given, with an explanation of blocking antibodies and the use of "developing" serum. Certain features of Rh typing, recently acceptable but now obsolete, are brought up to date.

(3:30) Discussion of papers 3, 4, and 5.

6. (4:00) *Evaluation of Procedures Recommended for Surgical Care of Uterine Prolapse.*

HAROLD O. JONES, M. D., F. A. C. S.,
Chicago, Ill.
Professor of Gynecology, Northwestern University; Chairman of Obstetrics and Gynecology, St. Luke's Hospital.

Trends in the developing of surgical methods to correct uterine prolapse are presented. A comparison of the fundamental differences in techniques is given. The outstanding features of so-called "standard operations" are illustrated. An opinion of the results of recent series of operations reported in the literature is offered.

7. (4:30) *Early Ambulatory Treatment in Gynecologic Surgery.*
FLOYD D. TAYLOR, Abilene.

Early ambulation is not new in surgery. Surgeons who have been skeptical of its use need fear no longer as it has more than proved itself. Postoperative complications are rarely seen and hospitalization time has been cut in half. It has stimulated surgeons to better preoperative, operative, and postoperative care of the patient.

Discussion to be opened by C. P. HAWKINS, Fort Worth.

8. (5:00) *A Critical Study of Maternal Mortality at St. Joseph's Infirmary, Houston, Texas.*
J. L. SPEZIA, Houston.

An analysis of 45 maternal deaths which have occurred since August, 1938, the opening date of the Maternity Hospital of St. Joseph's Infirmary, through December, 1946, is presented. The leading causes of death are enumerated and discussed relative to their prevention and/or therapeusis. Stress is placed on early and adequate prenatal care for patients.

Discussion to be opened by ROY L. GROGAN, Fort Worth.

Wednesday, May 7

8:00 a. m. to 12:00 noon

Danish Room, Fifteenth Floor, Hotel Adolphus

9. (8:00) *Evaluation of Low Cervical Cesarean Section With Chemotherapy and Antibiotics.*
R. P. MCDONALD, Fort Worth.

An analysis of cases is given. Extraperitoneal cesarean section is compared with low cervical section using penicillin.

Discussion to be opened by ASA A. NEWSOM, Dallas.

10. (8:30) *Surgical Treatments for Relief of Urinary Stress Incontinence.*
J. T. ARMSTRONG, Houston.

Surgical or obstetrical trauma frequently produces a partial or complete loss of function of the sphincter mechanism of the urethra. A high percentage of cases may be relieved by vaginal plastic operations which repair the damaged sphincter, restore and support the urethra to its normal length and position, and restore the bladder to its normal position. Failures may be relieved by an operation combining vaginal plastic procedures and transplantation of fascia under the urethra.

Discussion to be opened by HOWARD O. SMITH, Marlin.

11. (9:00) *Discussion of Controversial Details of Complete Hysterectomy.*
HAROLD O. JONES, Chicago, Ill.

Indications for the complete operation are enumerated. Technical operations are illustrated. The function of the uterine cervix in relation to pelvic supports, its high incidence of infection, and possible focus for malignancy are discussed. A study of the morbidities of the two operations is presented, with explanation of variations.

SYMPOSIUM ON ANESTHESIA

12. (9:30) *A Local Anesthesia Technique for Cesarean Section.*
E. K. BLEWETT, Austin.

Detailed description of a technique for performing cesarean section under local infiltration anesthesia. Illustrated with slides.

13. (9:50) *Obstetric Use of Demerol.*
JAMES T. DOWNS, Galveston.

A brief description of the pharmacologic action of demerol is given. Its use and contraindications as an analgesic agent are discussed, with recommended dosages. Its effects on the mother, length of labor, and the infant are compared to those of other agents and to conditions resulting when no analgesics are used.

14. (10:10) *Obstetrical Saddle Block Anesthesia from the General Practitioner's Viewpoint.*
R. R. SHEPPERD, Llano.

In 50 unselected deliveries, routine use was made of nupercaine and glucose in saddle block anesthesia. Anesthesia was instituted from 15 minutes to 12 hours before delivery. Injections were repeated when necessary. Minor side effects were observed in many cases. Serious bad effects were entirely absent. Many factors, chiefly its simplicity of administration, adapt this anesthesia to use by the general practitioner.

(10:30) Discussion of papers 12, 13, and 14 to be opened by EARL F. WEIR, Dallas.

15. (11:00) *Radiology as It Relates to Obstetrics.*
ROBERT D. MORETON and T. F. BUNKLEY, Temple.

The value of radiology as it relates to obstetrics, with stress upon diagnosis of pregnancy, pelvic anomalies, fetal anomalies, and death of the fetus in utero; x-ray pelvimetry; diagnosis of the position of the placenta; routine flat plates of the abdomen to determine position and presentation, as well as multiple pregnancy. The value of radiology to obstetrics is stressed, yet the art of obstetrics, per se, is not minimized. An attempt is made to bring out the clinical application of radiologic findings as they pertain to obstetrics, both in pregnancy and in labor. Conclusions drawn from the authors' records indicate that the relationship is sound and practical.

Discussion to be opened by J. E. KANATSER, Wichita Falls.

16. (11:30) *Salpingiosis: A Case Report.*
EVELYN GASS POWERS and O. N. HOOKER, Amarillo.

Report of a case of bilateral ovarian cysts in a patient 65 years of age, diagnosed pathologically as salpingiosis. Microscopic slides are shown. The case is reported because of the rare and unusual diagnosis.

Discussion to be opened by H. F. CONNALLY, JR., Waco.

SECTION ON EYE, EAR, NOSE, AND THROAT

Tuesday, May 6—Otolaryngology

1:30 p. m. to 5:30 p. m.

Rooms 5 and 6, Mezzanine Floor, Baker Hotel

Chairman—R. E. PARRISH, San Antonio.

Secretary—OSCAR MARCHMAN, JR., Dallas.

Guest of the Section—JOHN J. SHEA, Memphis, Tenn.

Guest Sponsor—JOHN MCLAURIN, Dallas.

1. (1:30) *War Blast Injuries to the Ear Drum.*
T. W. FOLBRE, San Antonio.

A series of ruptured ear drums from shell or mine blasts in the European Theater of Operations were observed and treated. Those cases where infection was present were treated by the "dry" treatment for otitis media. The use of peroxide or alcohol following rupture of membrana tympani seemed contraindicated. After all infection was removed, the perforations were given a chance to heal spontaneously. If they did not close and were not too large, an attempt was made to close them by the use of an artificial drum (cigarette paper) after trichloracetic acid cauterization of the edges of the perforations. The good results obtained, that is, closure of about 75 per cent of the perforations on which the artificial drums were used, were striking. An attempt is made to explain the mechanism of the artificial drum in the healing of tympanic membrane perforations. A special method of putting the artificial drum in place is described.

Discussion to be opened by BERT DEBORD, JR., Temple (5 minutes), and J. D. ROBERTS, Longview (5 minutes).

2. (2:00) *Tumors of the Larynx.*
OLIVER W. SUEHS, Austin.

A discussion of benign and malignant tumors of the larynx, with particular emphasis on cancer, its diagnosis and selection of treatment. A few lantern slides will be shown and, if feasible, the use of the esophageal voice will be demonstrated by a laryngectomized patient.

Discussion to be opened by TOM BARR, Dallas (5 minutes), and GEORGE S. MCREYNOLDS, Galveston (5 minutes).

3. (2:30) *Modern Trends in Diagnosis and Treatment of Paranasal Sinus Disease with Particular Reference to the Allergic Manifestations.*
KING GILL, Corpus Christi,

The diagnosis and treatment of paranasal sinus disease will be discussed. Special emphasis will be given to the allergic sinus in stressing the symptoms, nasal changes, cytology of the secretions, and management. Antibiotics and sulfa therapy will be mentioned in their relation to the treatment of the infected sinus.

Discussion to be opened by OSCAR MARCHMAN, SR., Dallas (5 minutes), and W. J. SNOW, Houston (5 minutes).

4. (3:00) *Office Problems in Otolaryngology.*

JOHN J. SHEA, M. A., M. D., F. A. C. S.
Memphis, Tenn.
Member, American Board of Otolaryngology.

The most common complaint in office practice is the management of postnasal discharge. This condition never requires surgical intervention. Treatment lies in correction of the intake of foods and of their metabolism after consumption. The proper prescribing of nasal drops and the method of proper administration will be considered. The safe handling of the itching ear will be covered in a comprehensive manner. The headache of cervical neuritis will be discussed and its modern treatment described.

Intermission.

5. (4:00) *Epistaxis.*
PALMER WOODSON, Austin.

Any trauma about the head or face, acute infectious diseases, constant vaporal or thermal irritations, or vascular diseases, may result in nasal hemorrhage. Nasal hemorrhage is easily controlled, but not infrequently it requires surgical intervention.

Discussion to be opened by JAMES W. WARD, Greenville (5 minutes), and G. HARDEN WOOD, Big Spring (5 minutes).

6. (4:30) *Tumors of the Parotid Gland.*
C. C. CODY, III, Houston.

A brief review of the anatomy of the parotid gland is made, with special emphasis on its relationship to the facial nerve. This also embodies some of the embryological developments of the gland. Tumors of the parotid gland are discussed and methods of treatment advanced. Particular attention is directed to the position and preservation of the facial nerve. A new and safe method of locating the facial nerve is mentioned. Some cases of parotid tumors in several local hospitals are reviewed briefly. The intention is to show that with a better understanding of parotid tumors and the anatomy of the facial nerve less hesitancy in resorting to radical surgical procedures on the parotid gland will be felt. In this way better surgical results should be obtained.

Discussion to be opened by FLETCHER CLARK, SR., San Antonio (5 minutes).

7. (5:00) *Irradiation of the Nasopharynx.*
A. N. CHAMPION, San Antonio.

Benign hyperplasia of the lymphoid tissue in the nasopharynx is a frequent occurrence, usually caused by infection, which may spread to adjacent structures, as well as cause recurrent infections of the pharynx. Surgical removal of the main mass of adenoids has been done for years, not always successfully. It is a blind operation, and many lymph nodules, inaccessible to surgery, remain as a possible source of future infection. Irradiation with a radium applicator offers a simple, safe, and successful method of treating this tissue. The technique, safety methods, and results in a series of cases will be discussed.

Discussion to be opened by J. CHARLES DICKSON, Houston (5 minutes).

Wednesday, May 7—Ophthalmology
8 a. m. to 12:00 noon
Rooms 5 and 6, Mezzanine Floor, Baker Hotel

8. (8:00) *Routine Office Procedure in the Diagnosis of Squint.*
A. E. MEISENBACH, Dallas.

Special emphasis will be given to the importance of correct diagnosis of squint. The methods of obtaining this diagnosis will be discussed, with the final evaluation of findings and the type of treatment indicated.

Discussion to be opened by SAM KEY, JR., Austin (5 minutes), and HAL HARDIN, Dallas (5 minutes).

9. (8:30) *Fascia-Lata Transplant in Regression of Retrotarsal Fat in Ophthalmostoresis* (motion picture).
W. O. MURPHY, Amarillo.

A description of a fascia-lata transplant for the purpose of filling up the unsightly depression frequently present in persons who have had eyes enucleated between the supercilium and the normal anterior curve of the superior palpebrum.

Discussion to be opened by EDWARD D. MCKAY, Temple (5 minutes), and MAXWELL THOMAS, Dallas (5 minutes).

10. (9:00) *Management of Intra-Ocular Foreign Bodies.*
BEN HUTCHINSON, Lubbock.

The consideration of intra-ocular foreign bodies resolves itself chiefly into a demonstration of the presence of a foreign body, its localization, if possible the determination of its nature, and the choice of surgical procedure to be used in its removal. The solution to these problems is based on the history, several roentgenologic techniques, and various methods of examination of the eye. The management of such cases depends on the findings. Diverse types of cases are reviewed. Definitive methods of management and after care are discussed. Anticipated results are considered.

Discussion to be opened by F. H. NEWTON, Dallas (5 minutes), and W. J. WOOLSEY, Waco (5 minutes).

11. (9:30) *Prevention and Treatment of Complications in Cataract Surgery.*
EVERETT L. GOAR, Houston.

The ophthalmic surgeon who does many cataract operations is plagued by unpleasant complications. The patients are usually elderly, with arteriosclerosis and often other physical ailments. Not infrequently the eyes have other diseases. Many patients are noncooperative, and not a few have cerebral arteriosclerosis so that the shock of operation, together with unfamiliar surroundings and bandaged eyes, is enough to cause a troublesome disorientation. It is therefore surprising to obtain as high a percentage of good results as is secured. The safety devices used to enhance the chances of success will be discussed, as well as the treatment of complications as they arise. Two cases selected at random will be reported to illustrate two complications that seem unavoidable.

Discussion to be opened by V. R. HURST, Longview (5 minutes), and WILLIAM E. VANDEVERE, El Paso (5 Minutes).

12. (10:00) *Preglaucoma, Its Diagnosis and Management.*
S. K. STROUD, Corpus Christi.

A general discussion of the early symptomatology and findings leading to diagnosis of the preglaucomatous syndrome. The differential diagnosis and treatment of the first stages of the condition are stressed.

Discussion to be opened by L. C. HEARE, Port Arthur (5 minutes), and BURBANK WOODSON, Temple (5 minutes).

13. (10:30) *Ocular Contusions and Their Sequelae.*
M. W. MCCURDY, San Antonio.

A thorough description of the immediate complications found both on external and internal examination following ocular contusions will be given, as well as those complications which can be expected later. Suggestions for treatment will be discussed in detail.

Discussion to be opened by C. R. LEES, Fort Worth (5 minutes).

14. (11:00) *Universal Adoption of a Method of Appraisal of Visual Efficiency.*
KEITH SIMPSON, Kerrville,

Visual efficiency is based mainly on three factors, central visual acuity, fields of vision, and the function of extrensic ocular muscles. Common and practical methods of determining these factors will be given, with suggestions as to the percentage of disability and compensation to be considered.

Discussion to be opened by FREDERIC THORNE, Fredericksburg (5 minutes), and JOHN L. MATTHEWS, San Antonio (5 minutes).

15. (11:30) *Early Postoperative Ambulation of Cataract Patients.*
STANLEY SMITH, Houston.

A report on a series of 60 nonselected cataract patients with monocular dressings who were ambulatory on the morning of the first postoperative day until discharged from the hospital. The paper will include preoperative and postoperative treatment, operative method, and final visual acuity. This report is compiled from surgery done in 1946 while the author was a resident in ophthalmology at Jefferson Davis Hospital, Houston.

Discussion to be opened by RAY K. DAILY, Houston (5 minutes), and A. E. JACKSON, Fort Worth (5 minutes).

SECTION ON RADIOLOGY AND PHYSIOTHERAPY

Tuesday, May 6
1:30 p. m. to 5:30 p. m.
Parlor F, Sixth Floor, Hotel Adolphus

Chairman—L. M. GARRETT, Corpus Christi.
Secretary—H. E. WHIGHAM, McAllen.
Guest of the Section—HARRY M. WEBER, Rochester, Minn.
Guest Sponsor—DAVIS SPANGLER, Dallas.

1. (1:30) *Roentgen Therapy for Lymphoid Hyperplasia of the Nasopharynx.*
E. E. SEEDORF and EDWARD D. MCKAY, Temple.

The significance of lymphoid hyperplasia in the nasopharynx and factors influencing production of symptoms are considered. The individual advantages of roentgen therapy and of radium therapy in this field of treatment are evaluated. The techniques of radiation are considered in detail. As indications for this therapy, the audiometer findings, direct and indirect inspections of the nasopharynx, together with the history of the patient are paramount in instituting treatment.

Discussion to be opened by RICHARD BARR, Beaumont.

2. (2:00) *The Use of Radioactive Isotopes in Diagnosis and Treatment.*
J. R. MAXFIELD, Dallas.

The history of radioactive isotopes in medicine is briefly reviewed. This includes their use as tracers in research or metabolism as well as their use in therapy. The use of radioactive phosphorus in treating polycythemia vera and the leukemias is considered in some detail. The new techniques for treating skin lesions with radioactive substances in blotting paper is described.

Discussion to be opened by WILLIAM MARR, Galveston.

3. (2:30) *The Role of Calcium in Roentgenologic Bone Disorders.*
JOHN J. HINCHEY, San Antonio.

Present knowledge of normal calcium metabolism is summarized, including requirements and factors affecting its absorption, blood level, and excretion, as well as calcification and decalcification. The mechanisms of production of hyperthyroidism, hyperparathyroidism, osteomalacia, senile osteoporosis, and

Paget's disease are presented. A few new similar entities such as thiocyanate osteoporosis and fluorine osteosclerosis are mentioned, and recent trends in therapy are outlined. This presentation is accompanied by lantern slides, diagrammatically representing calcium metabolism in these conditions.

Discussion to be opened by BEN DUBILIER, Austin.

4. (3:00) *The Conduct of the Roentgenologic Examination of the Colon and Small Intestine.*

HARRY M. WEBER, M. D.
Rochester, Minn.
Associate Roentgenologist, Section on Roentgenology, Mayo Clinic; Assistant Professor of Radiology, Mayo Foundation, University of Minnesota.

The techniques of examination of the small intestine and colon, including the conduct of fluoroscopic and roentgenographic examinations of both the small bowel and colon and the conduct of double contrast studies of the colon. A review of the diagnostic yield is made and some of the limitations of the methods are discussed. The indications for and contraindications to the application of the methods are outlined.

5. (3:45) *Calcification in and about the Kidneys.*
GLENN D. CARLSON, Dallas.

A brief discussion of the causative factors in the development of urolithiasis is given. Lesions occurring in structures adjacent to the kidneys, in which calcific deposits may be seen, include cholelithiasis, psoas abscess, mesenteric lymphadenopathy, and hematoma. Roentgenographic procedures helpful in differentiating the renal and nonrenal calcifications are also discussed.

Discussion to be opened by J. WILSON DAVID, Corsicana.

6. (4:15) *Gastro-Intestinal Symptoms in Disease of the Urinary Tract, a Roentgenologic Report.*
MILTON DAVIS, San Antonio.

Consideration is given a group of patients who report to their physicians with gastro-intestinal symptoms and who are later proved to have disease of the genito-urinary tract after roentgen and clinical examinations of the gastro-intestinal system have shown nothing to account for the symptoms. The anatomic and physiologic reasons for the presence of gastro-intestinal symptoms in genito-urinary disease are discussed. The more common genito-urinary conditions producing such symptoms are discussed and illustrative case reports with roentgenograms are presented.

Discussion to be opened by TOM BOND, Fort Worth.

Wednesday, May 7
8:30 a. m. to 12 noon
Parlor F, Sixth Floor, Hotel Adolphus

7. (8:30) *Roentgenographic Aspects of Problems in Thoracic Surgery.*
L. M. SHEFTS, San Antonio,

Presentation of roentgenograms, bronchograms, and histories, with photographs of specimens of problem cases in thoracic surgery. Cases presented with emphasis on the roentgenographic aspects will include proved carcinomas, adenomas, abscesses, fungus infection, bronchiectasis, congenital cysts, postoperative atelectasis, and nonopaque foreign bodies.

Discussion to be opened by H. KLAPPROTH, Sherman.

8. (9:00) *Radiation Treatment of Cancer of the Cervix.*
GEORGE TURNER, El Paso.

Consideration is given to the nature of the lesion with respect to the type cell from which it arises, methods of extension, tissues to which it extends, grades, and stages; and consequently, the necessity for an even and homogeneous radiation of the pelvic space to give a dosage lethal to cancer cells. To this end external, transvaginal, and radium radiation is employed. Follow-up observation, including re-check biopsies, treatment of necrotic lesions, and general care, is discussed. (Lantern slides.)

Discussion to be opened by THOMAS RUSSELL, Houston.

9. (9:30) *Indications for Special Technique in Obstetrical Radiology.*
MARTIN SCHNEIDER, Galveston.

A summary of indications and technique in special studies of the pregnant uterus and of the fetus. Attention will be directed to routine cephalo-pelvimetry of primiparous women and of multiparous women, with a history of previous obstetrical difficulty. Consideration of the indications for, and the usefulness of, uterine soft tissue studies, diagnostic signs in ectopic pregnancy, and the diagnostic procedures for determination of placenta previa.

Discussion to be opened by PALMER WIGBY, Houston.

10. (10:00) *Roentgen Pelvimetry.*
R. E. REUTER, San Antonio.

The discussion concerns types of obstetrical pelves, the methods of their demonstration and measurements, with a discussion of the features to be taken into account in predicting whether labor appears possible or not. Illustrative cases will be presented.

Discussion to be opened by PALMER WIGBY, Houston.

11. (10:30) *Hysterosalpingography.*
CHARLES MARTIN, Dallas.

About 50 per cent of the sterile women have organic changes in the fallopian tubes. Hysterosalpingography demonstrates the presence of obstruction, and many other abnormal conditions in the adnexa. The maintenance of oil pressure in the tubes for a period of 30 to 40 minutes often establishes patency and renders pregnancy possible. The results obtained in a large series of cases will be reported.

Discussion to be opened by J. R. MAXFIELD, Dallas.

12. (11:00) *Sticker Films* (proved cases only).
On arrival please present your films with a brief essential history to H. E. Whigham.

SECTION ON PUBLIC HEALTH

Tuesday, May 6
1:30 p. m. to 5:30 p. m.
North Room, Fifteenth Floor, Hotel Adolphus

Chairman—ELLIOTT MENDENHALL, Dallas.
Secretary—B. M. PRIMER, Austin.
Guest of the Section—WILSON G. SMILLIE, New York, N. Y.
Guest Sponsor—J. W. BASS, Dallas.

1. (1.30) *Chairman's Address: Tuberculosis Eradication—A Possibility.*
ELLIOTT MENDENHALL, Dallas.

The principles of tuberculosis control are reviewed. The hope is expressed that means for the eradication of the disease will yet be found. While researchers work for a specific cure, we must continue to find, treat, prevent, and teach tuberculosis. Some of the experiences of the Dallas Tuberculosis Clinic are cited in its relation to an over-all eradication program.

(1:50) Discussion to be opened by H. SMITH, Austin.

2. (2:00) *Recent Developments in Control Measures for Acute Respiratory Infections.*

WILSON G. SMILLIE, M. D.,
New York, N. Y.
Professor of Public Health and Preventive Medicine, Cornell University Medical College.

The recent developments in the epidemiology of certain acute respiratory infections are presented. The effect of these in-

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vestigations upon control methods is shown. Chief emphasis is placed upon influenza, lobar pneumonia, bronchopneumonia, and primary atypical pneumonia. A discussion of the influence of air sterilization upon disease prevention is also presented.

3. (2:30) *Trends in Public Health in Texas.*
GEORGE W. COX, Austin.

A short review of the work accomplished in public health in Texas, showing a trend toward the formation of more local health units in order that full-time service may be available to all citizens. Research in many of the diseases such as cancer, heart, and tropical diseases; better methods of disease control, and pooling all available health facilities for the common good are discussed.

(2:50) Discussion to be opened by B. E. PICKETT, SR., Carrizo Springs.

4. (3:00) *Public Health Responsibilities at the National, State, and Local Levels.*
J. W. BASS, Dallas.

The need for a re-evaluation of responsibilities for health work at the local, state, and federal levels is discussed. The proper designation of duties and activities at the different governmental levels is emphasized in its relation to the formulation and execution of a more efficient and economic type of health program. Public health administrators must satisfy their respective governing bodies that the money spent on health activities is securing the most complete and comprehensive program for the investment.

(3:20) Discussion to be opened by HAROLD M. WILLIAMS, Fort Worth.

5. (3:30) *The Use of Statistical Data in Preventive Medicine and Modern Public Health Administration.*
L. P. WALTER, Austin.

Statistical terminology and its application to the problems of the health department are discussed. Illustrations of the use of statistical methods in the state and local levels are given. Application of the statistical method to morbidity and mortality and the use of cost accounting are covered. Procedures for the solution of health problems are discussed.

(3:50) Discussion to be opened by DUDLEY A. REEKIE, San Antonio.

6. (4:00) *Laboratory Aids in Diagnosis of Diarrhea and Enteritis in Children.*
S. W. BOHLS, Austin.

Today the modern laboratory can aid the pediatrician and general practitioner of medicine in the diagnosis of diarrhea in children. Salmonellosis, Shigellosis, amebiases, and virus infections can be determined in laboratories equipped and staffed to make the laboratory examinations. The technique for obtaining and submitting specimens to the laboratory is described. Laboratory procedures and the interpretations are briefly discussed.

(4:20) Discussion to be opened by F. WILLIAM HOEHN, Waco.

7. (4:30) *Public Health Activities in Alaska.*
DAVID M. COWGILL, Abilene.

The history of the development of the health program in Alaska is followed by a discussion of the health problems of that area. Problems encountered in Alaska, while similar to those seen in any new and pioneer section of the world, present certain characteristics found only in that section of America.

(4:50) Discussion to be opened by J. E. PEAVY, Sweetwater.

8. (5:00) *A Venereal Disease Control Officer in the European Theater of Operations.*
JOSEPH WOLFE, Dallas.

Problems associated with the mass movements of troops from the United States to England and Europe are discussed. Organization of venereal disease in the European Theater of Operations in 1942 is given, with means and measures used to achieve optimum results, based on problems associated with contact with civilian populations of both allies and enemy.

Wednesday, May 7

8:00 a. m. to 12:00 noon

North Room, Fifteenth Floor, Hotel Adolphus

9. (8:00) *Texas Public Health Programs Need Texas Teamwork.*
WILLARD OGLE, D. D. S., Secretary-Editor, Texas State Dental Society, Dallas.

The need for professional support in the development and stimulation of health activities throughout Texas is discussed at length. Teamwork by physicians, dentists, and other professional groups in the program of education of the public to the importance of extending health services to all the people through adequate appropriations by the Legislature is given as the best preventive against the introduction of medical policies detrimental to the practice of medicine.

(8:20) Discussion to be opened by GEORGE A. GRAY, San Angelo.

10. (8:30) *Experiences with Recombined Milk.*
GORDON FISHER, Corpus Christi.

Experience with the use of recombined milk is discussed and some of the problems associated with its use during the war and postwar period are covered.

(8:50) Discussion to be opened by AUSTIN E. HILL, Houston.

11. (9:00) *The Private Physician's Attitude Toward School Health Work.*
I. P. BARRETT, Fort Worth.

Following a historical review of school health programs, the need for a closer cooperation between the family physician and the schools, both those schools having a full-time health service and those with none, is discussed. All activities of the private physician in this program of the schools will aid in the securing of optimum growth and development for all children. The need for a more careful and sympathetic understanding of the problems of communicable disease control, handicapped children, and preparation of beginners for entrance to school is discussed.

(9:20) Discussion to be opened by HORACE E. DUNCAN, Dallas.

12. (9:30) *Progress on Tuberculosis in Smith County.*
C. B. YOUNG, Tyler.

The beginning and progress of the Smith County Tuberculosis Clinic is reviewed, and its association with the Smith County Health Unit is shown. The results of the clinic since its beginning, and the pleasant and cooperative relationships existing between organized medicine and official health agencies of the community are covered.

(9:50) Discussion to be opened by W. R. ROSS, Tyler.

13. (10:00) *The Control of Tuberculosis Among College Students in Texas.*
J. EDWARD JOHNSON, Austin.

A screening roentgen-ray survey covering 12,000 college students is reported and an outline of minimum requirements for adequate control of tuberculosis among college students is given. Annual surveys of classes in residence, provision for immediate isolation and exclusion of active cases, and extension of a control program to the faculty, employees, and food handlers serving meals to students are discussed. The need for adequate rehabilitation programs is stressed.

(10:20) Discussion to be opened by J. LEEPER HAWLEY, Dallas.

14. (10:30) *Gynecologic Investigation of a State Eleemosynary Institution.*
WILLARD R. COOKE, Galveston, and JOHN O. WEAVER, Austin.

A report of the first of a series of gynecologic investigations to be done in the eleemosynary institutions of the state is given. This work, done under the direction of the Department of Obstetrics and Gynecology, Medical Branch, University of Texas, is made possible by a grant from the Eli Lilly Company. A review of the gynecologic techniques used in the study is given, together with a report of the lesions found in the examinations.

(10:50) Discussion to be opened by ROY L. GROGAN, Fort Worth.

15. (11:00) *Your Health and the Soil.*
E. P. MCKINNEY, Nacogdoches.

The fundamental relationships between soil fertility and plant, animal, and human nutrition are discussed. The conclusion makes a plea for dissemination of available knowledge and suggests a plan of action.

(11:20) Discussion to be opened by M. L. FULLER, Brownwood.

16. (11:30) *General Discussion.*

SECTION ON CLINICAL PATHOLOGY

Tuesday, May 6

1:30 p. m. to 5:30 p. m.

Room 4, Mezzanine Floor, Baker Hotel

Chairman—CHARLES PHILLIPS, Temple.

Secretary—ELLEN D. FUREY, Beaumont.

Guest of the Section—THOMAS B. MAGATH, Rochester, Minn.

Guest Sponsor—J. L. Goforth, Dallas.

1. (1:30) *Chairman's Address: The Pathologist and the Tumor Clinic Program.*
CHARLES PHILLIPS, Temple.

For seven years the author has been the surgical pathologist consultant in a standard, approved cancer clinic and has come to understand the full and proper relationships of the members of such a group. He has found it stimulating, thought-provoking, and a pleasant way to keep up-to-date on clinical problems of diagnosis and treatment of cancer patients. He invites fellow pathologists to avail themselves of similar privileges when the opportunity presents itself.

2. (1:50) *Cancer Education in Texas and the Cancer Program.*
R. LEE CLARK, JR., Houston.

Four principal agencies are actively engaged in the cancer control program for the state of Texas. These are the Cancer Committee of the State Medical Association, the Texas State Department of Health, American Cancer Society, and M. D. Anderson Hospital for Cancer Research. The field of activity of each of these agencies in the state program is considered in regard to service and education. The pathologists have a vital role in this program. New techniques for pathologic diagnosis are being developed. One of these is the Papanicolaou method of using vaginal smears as a screening test for cancer of the cervix.

(2:10) Discussion to be opened by CHARLES PHILLIPS, Temple.

3. (2:20) *Adenomatoid (Angiomatoid) Formations of Genital Organs.*
HARBERT DAVENPORT, JR., Houston.

Tissue formations having both angiomatous and adenomatous histologic characteristics occur in the epididymis and testicular tunics in the male, and in the wall of the fallopian tube, the ovary, and the uterus of the female. In many instances the formations have the appearance of benign neoplasms. The tumor occurring in the tunic of the testis or between the epididymis and testis may be considered a malignant tumor of the testis by the clinician. The histologic picture of some of the tumors may suggest adenocarcinoma to the pathologist. The literature is briefly reviewed. Illustrations of the gross and histologic appearance of the tumors are shown.

(2:40) Discussion to be opened by C. T. ASHWORTH, Dallas.

4. (2:50) *Laboratory Aspects of Tropical Diseases.*

THOMAS B. MAGATH, Ph. D., M. D., F. A. C. P., Rochester, Minn.
Chief, Division of Clinical Laboratories, Mayo Clinic, and Professor of Pathology and Parasitology, Mayo Foundation, University of Minnesota.

Physicians in the United States have had, as a whole, but little experience in the diagnosis of tropical diseases. The large number of members of the Armed Forces and others who were exposed to diseases in the tropics during the war has called attention to the importance of being able to diagnose or eliminate from consideration these exotic diseases. The laboratory plays an important role in such aspects of tropical medicine and methods of laboratory examination will be discussed, with specific findings illustrated by lantern slides.

(3:20) Discussion.

5. (3:30) *Primary Carcinoma of the Lung: Report of 50 Cases.*
D. W. QUICK, JR., and PAUL BRINDLEY, Galveston.

A brief summary of the literature, and a report based upon approximately 50 cases from the John Sealy Hospital and the Department of Pathology of the University of Texas School of Medicine, along with the correlation of the clinical and pathologic findings.

(3:50) Discussion to be opened by A. O. SINGLETON, Galveston.

6. (4:00) *Uses and Abuses of Coagulation and Bleeding Time Preceding Tonsillectomy.*
W. L. SHEPEARD, McAllen.

Historical resume of the procedure with comments concerning its abuses. Is it of more importance in tonsillectomies than in other operations? As a routine procedure are other tests of more importance? What should be the present status of coagulation and bleeding times?

(4:20) Discussion to be opened by A. B. CAIRNS, Dallas.

7. (4:30) *Melanomas: Experience With a Series Over a Period of Years.*
E. M. WINSETT, Galveston.

A study of melanomas occurring in the Galveston area over a period of 25 to 30 years.

(4:50) Discussion to be opened by C. F. LEHMANN, San Antonio.

8. (5:00) *Examination of Body Fluids for Diagnosis of Malignancy.*
PETER M. MARCUSE, and W. W. COULTER, SR., Houston.

A report of experiences at Jefferson Davis Hospital within four years. The material includes abdominal fluid (27 cases), chest fluid (24 cases), and bronchial secretion (8 cases). The various problems in the technique of handling these specimens are discussed, together with the difficulties in interpreting the findings. Results are given on the basis of clinical follow-up.

(5:20) Discussion to be opened by S. W. BOHLS, Austin.

Wednesday, May 7

8:30 a. m. to 10:30 a. m.

Palm Garden, Twenty-First Floor, Hotel Adolphus

9. (8:30) *Clinical-Pathological Conference.*
C. T. ASHWORTH and HENRY WINANS, Dallas.

11:00 a. m. to 12:00 noon

Room 4, Mezzanine Floor, Baker Hotel

10. (11:00) *Round-Table Discussion: Cardiolipin Tests for Syphilis.*
JOHN J. ANDUJAR, Chairman, Fort Worth; S. W. BOHLS, Austin; H. B. WILLIFORD, Beaumont; and W. N. POWELL, Temple.

SECTION ON PEDIATRICS

Tuesday, May 6

1:30 p. m. to 5:30 p. m.

Parlor E, Sixth Floor, Hotel Adolphus

Chairman—JAMES H. PARK, JR., Houston.

Secretary—HAROLD T. NESBIT, Dallas.

Guest of the Section—WALDO E. NELSON, Philadelphia. Pa.

Guest Sponsor—H. LESLIE MOORE, Dallas.

1. (1:30) *Chairman's Address: Treatment of Acute Infectious Mononucleosis.*
JAMES H. PARK, JR., Houston.

Attention is directed to an old disease entity which often is unrecognized. It may occur in sporadic or epidemic form. In children the condition is far less serious than in adults, although the former may exhibit alarming symptoms during the course of the disease. Diagnostic criteria are outlined. The use of commercial pooled human blood plasma has produced striking clinical improvement.

2. (2:00) *Reading Difficulties in Children.*
EUGENE ATEN, Dallas.

Reading problems as a diagnostic and therapeutic disorder come to the attention of physicians with increasing frequency. The practical diagnostic criteria and the theories involved are presented. Suggestions as to the remedial methods that may be used are outlined.

Discussion to be opened by HUGO KLINT, Austin, and E. G. SCHWARZ, Fort Worth.

3. (2:30) *The Diagnosis of Atypical Pneumonia, Etiology Unknown, in Pediatric Practice.*
DAVID GREER, Houston.

This type of pneumonia is the most frequently encountered of all acute pneumonic conditions seen in pediatric practice in the Gulf Coast area. An effort is made to set forth its salient diagnostic characteristics so as to facilitate its more general early and accurate detection (lantern slides).

Discussion to be opened by DON W. CHAPMAN, Houston.

4. (3:00) *Diabetes Mellitus in Children, with Emphasis on Treatment of Acidosis and on Management in the Non-Acidotic Stage.*

WALDO E. NELSON, M. D.,
Philadelphia, Pa.
Professor of Pediatrics, Temple University Medical School.

The significance of the degree (severity) of acidosis, as well as its duration, in relation to the probability of recovery from diabetic coma will be discussed, and an attempt will be made to evaluate the importance of alkali and glucose in the total therapy of this phase of diabetes mellitus. Details incident to the establishment of a satisfactory maintenance status will be described. Emphasis will be placed upon consideration of the child as a whole, recognizing that control of his disease is important only insofar as it makes possible adequate physical and mental growth and development and social adjustment.

5. (3:30) *Loffler's Syndrome (Eosinophilic Pneumonia): Report of a Case in an Infant.*
GEORGE T. O'BYRNE, Corpus Christi.

A syndrome described by Löffler in 1932, characterized by transient pulmonary infiltrations and blood eosinophilia, was observed in an infant of 7 months. The condition persisted for ten weeks, during which time the eosinophile count varied from 10 to 50 per cent and there were many changes in the pulmonary infiltrations. The disease apparently is rare in infancy and probably is due to a vascular response to a wide variety of allergens. (Lantern slides.)

Discussion to be opened by FRANCES M. LOVE, Dallas.

6. (4:00) *Cystic Fibrosis of the Pancreas.*
BYRON YORK, Houston.

Presentation of a series of 10 cases of fibrocystic disease of the pancreas with a discussion and several appropriate illustrations by slides.

Discussion to be opened by FLOYD A. NORMAN, Dallas.

7. (4:30) *Report on the Activities of the Texas Child Health Program for the First Three years.*
ARILD E. HANSEN, Galveston.

The Child Health Program, created by University of Texas authorities and supported in part by a grant from the William Buchanan Foundation, has included the following activities: (1) education—teaching medical students, enhancing the pediatric nursing program, and developing a residency training program; (2) research—lipid metabolism, penicillin and congenital syphilis, and diarrhea and dysentery; (3) specific projects—six pediatric conferences, lectureships, and clinics, participation in various meetings, and publication of thirty-five articles (all of these projects in cooperation with professional organizations), and establishment of an experimental animal colony and laboratories.

Wednesday, May 7
8:00 a. m. to 12:00 noon
Parlor E, Sixth Floor, Hotel Adolphus

8. (8:00) *Genital Abnormalities in Children as Seen by the Urologist.*
H. M. SPENCE and SIDNEY S. BAIRD, Dallas.

Genital abnormalities of pediatric interest are due (1) to congenital defects of development, or (2) to disturbance of function of the endocrine glands. Hypospadias and epispadias, examples of the former, are amenable to surgical correction. Many so-called hermaphrodites are in reality third degree hypospadiacs. Endocrine dysfunction may result in pseudo-hermaphroditism in girls or premature virilism in boys. Illustrative cases with their management are presented. Persistent gynecomastia in boys is best corrected surgically. There is a wide variation in size of the normal male external genitalia. A case of true hypoplasia of unknown etiology is presented.

Discussion to be opened by ARTHUR GROLLMAN, Dallas, and MICHAEL O'HEERON, Houston.

9. (8:30) *Panhematopenia and Splenomegaly.*
NUEL C. WINDROW, Galveston.

The anatomy and physiologic functions of the spleen are reviewed. The function of the reticulo-endothelial tissue of the spleen is emphasized, especially that affecting sequestration of the normal cellular elements of the peripheral blood by the fixed macrophages. Pathologic accentuation of this function may result in the development of hemolytic anemias, primary thrombocytopenic purpura, primary splenic neutropenia, or splenic panhematopenia. In many instances splenectomy is indicated. Surgery, however, should be undertaken only after a complete clinical work-up and thorough laboratory investigations, including an adrenalin test and a bone marrow biopsy. Two examples of secondary splenic panhematopenia are cited.

Discussion to be opened by GEORGE W. SALMON, Houston.

10. (9:00) *Amyotonia Congenita Occurring in Twins, with Autopsy Findings.*
E. B. BRANDES, Houston.

Two cases of amyotonia congenita (Oppenheim's disease) occurring in identical twins are presented, with clinical findings on both and complete neuro-anatomic studies on one. The literature is reviewed and the various theories of the pathogenesis of this disease are presented.

Discussion to be opened by GLADYS FASHENA, Dallas, and R. L. NELSON, Wichita Falls.

11. (9:30) *Clinical Application in Pediatrics of Some New Concepts in Body Mechanics in a Child's Development.*
THOMAS J. MCELHENNEY, Austin,

A discussion of the pediatrician's use of screening techniques in his office and in collaboration with the classroom teacher to supplement diagnostic procedures in determining the total needs of the child. The screening techniques to be demonstrated will be based on the research findings in child development by the Division of School Health Services of the State Department of Health. Case material in relation to this program will be presented from the author's own practice.

Discussion to be opened by C. O. TERRELL, Fort Worth, and DAVID GREER, Houston.

12. (10:00) *Left Dominant Child.*
EMMETT BYROM, Dallas.

The special motor disability which most widely interferes with ordinary tasks among school children is left-handedness. Natural movements for 95 per cent of the population are from the body to the right. Natural movements of the remainder are to the left. The problem confronting the left dominant child is to learn to perform right-handed movements to the best of his ability. This task gives such a child 20 per cent more work to do. Left dominant children should have early corrective training, so that right movements may be more easily performed.

Discussion to be opened by LUCIUS D. HILL, JR., San Antonio, and W. P. ROBERT, Beaumont.

13. (10:30) *Acute Laryngotracheobronchitis.*
MERRILL W. EVERHART, San Angelo.

An epidemic of respiratory infections in which laryngeal and obstructive symptoms played a dominant role occurred in San Angelo during the late fall and winter of 1946-1947. Most of the cases varied from mild to moderately severe and responded to chemotherapy and symptomatic treatment. Four severe cases required tracheotomy; all patients recovered after a variable

course. Early diagnosis and early tracheotomy before exhaustion occurs is fundamental, and the maintenance of open airways and chemotherapy are important in the postoperative period.

Discussion to be opened by C. S. E. TOUZEL, Fort Worth, and James H. Harris, Marshall.

14. (11:00) *Sodium Citrate in the Treatment of Lead Encephalopathy.*
ERLE E. WILKINSON, Galveston.

The frequency of encephalopathy as a clinical manifestation of lead poisoning in children is pointed out and the diagnosis is discussed briefly. The literature on the subject of treatment by means of sodium citrate is reviewed. A case of lead encephalopathy in a child treated by sodium citrate is reported. It is concluded that this method of treatment seems the most logical of any known therapy at present and that it deserves further clinical trial.

Discussion to be opened by J. G. YOUNG, Dallas.

EXHIBITS

SCIENTIFIC EXHIBITS

The scientific exhibits will be displayed in the hall of the Sixth Floor, Hotel Adolphus. Motion pictures will be shown continuously in Parlor D, Sixth Floor, Hotel Adolphus.

A list of exhibitors follows:

American Cancer Society, Texas Division: "Teamwork in Cancer Diagnosis." Mr. J. Louis Neff, Houston, will be in charge.

James A. Greene, Houston: "Metabolic Disturbances in Hypogonadism and Hypopituitarism."

Joseph M. Hill, Sol Haberman, Ph. D., and E. E. Muirhead, Dallas: "CDE (Rh-Hr) Blood Antigens."

Herbert E. Hipps, Waco: "Muscle Training in Infantile Paralysis."

Karl J. Karnaky, Houston: "Gynecological Operations."

Mead Johnson & Company: "Pediatric Antiques." Mr. Edward W. Brady, Dallas, will be in charge.

Minter Clinic, San Antonio: "Low Sodium, High Fluid Intake in Treatment of Edema." Research carried out by the clinic. R. E. Nitschke will be in charge.

Texas State Department of Health: Title to be announced.

L. L. D. Tuttle, Houston: "Vagus Nerve Resection for Peptic Ulcer."

University of Texas Medical Branch, Department of Anesthesiology: "Malpositions on the Operating Table." H. C. Slocum, E. A. Hoeflich, and C. R. Allen will be in charge.

University of Texas Medical Branch, Department of Oto-Rhino-Laryngology: "Foreign Bodies of the Food and Air Passages." George S. McReynolds and Fred W. Shelton will be in charge.

MOTION PICTURES

Abbott Laboratories, Chicago, Ill.: (1) "Intravenous Anesthesia."

Becton Dickinson and Company, Rutherford, N. J.: (1) "Continuous Caudal Analgesia"; (2) "Hypodermic Syringes and Needles: Their Function and Care"; (3) "Athletic Type of Injuries; Their Prevention and Immediate Care"; (4) "Varicose Veins and Their Complications."

British Information Services, Houston: (1) "Surgery in Chest Diseases."

Billy Burke Productions, Hollywood, Calif.: (1) "Safer Gastrectomy."

Ray K. Daily, Houston: (1) "Operation on the Eyelids: Kuhnt-Zymanowski Operation for Senile Ectropion"; (2) "Cataract Surgery."

Davis and Geck, Brooklyn, N. Y.: (1) "Splenectomy."

Karl John Karnaky, Houston: (1) "Floraquin"; (2) "Trichomonas Vaginalis and Leukorrhea."

Linde Air Products Company, New York: (1) "Oxygen Therapy in Heart Disease."

Mead Johnson and Company, Evansville, Ind.: (1) "Cholecystectomy"; (2) "Hysterectomy"; (3) "A Low Cervical Cesarean Section"; (4) "Introduction to Extracellular Fluid"; (5) "Significance of Complete Preventive Medical Program for Children"; (6) "Introduction to Adolescence"; (7) "Spontaneous Delivery"; (8) "Multiple Pregnancy."

National Foundation for Infantile Paralysis, New York: (1) "New Horizons"; (2) "Accent on Use."

Ortho-Products, Inc., Linden, N. J.: (1) "Human Fertility."

Standard Brands, Dallas: (1) "Golden Glory"; (2) "Modest Miracle."

Winthrop Chemical Company, New York: (1) "Regional Anesthesia."

TECHNICAL EXHIBITS

The technical exhibits will be displayed on the lobby floor of the Hotel Adolphus, headquarters for the annual session. These exhibits provide much of educational value for the physician. Without the armamentarium furnished by the concerns which exhibit at annual sessions, doctors would be seriously handicapped in the practice of scientific medicine. These exhibits are worth all the time and attention registrants at the session can give them. They should be visited without fail.

The list of exhibitors follows:

BOOKS

The C. V. Mosby Company will welcome visitors to booth 13, where its representative line of medical publications will be displayed. New 1946 releases of timely interest will include Ackerman-Regato "Cancer," Clendening-Hashinger "Methods of Diagnosis," Treiger "Atlas of Cardiovascular Diseases," Wiener "Skin Manifestations of Internal Disorders," and Rubin "Uterotubal Insufflation." The company cordially invites examination of these books, as well as the many other titles that will be shown.

W. B. Saunders Company, publishers, represented by its Southern Agents, **J. A. Majors Company** of New Orleans and Dallas (booths 8 and 9), will exhibit its complete line of books including Hyman's "Integrated Practice of Medicine," 4 vols. and index; Bockus' "Gastroenterology," 3 vols. and index; Allen, Barker and Hines' "Peripheral Vascular Diseases"; Russell's "Practical Malariology;" Mason's "Pre and Post Operative Treatment," new second edition, and many others.

DIETETIC SUPPLIES

The Borden Company invites attention in booth 14 to Gerilac, a vitamin-fortified powdered milk for well-rounded nutrition in convalescence, pre- and postoperative diets, geriatrics, pregnancy and lactation, and soft and liquid diets. Likewise exhibited will be Borden's long established products for infant feeding: Biolac, Dryco, Mull-Soy, Merrell-Soule Special Milks, general purpose Klim, and Beta Lactose.

H. W. Kinney and Sons, Inc., cordially invites physicians of the State Medical Association of Texas to attend the Kinney exhibit in booth 17, featuring Cartose and Kinney's Yeast preparations. Messrs. A. G. Boyd, R. Yates Dillard, and D. W. Betts will be in attendance.

M & R Dietetic Laboratories (booth 3) will display Similac, a food for infants deprived either partially or entirely of breast milk. Mr. E. J. Bryant will appreciate the opportunity to discuss the merit and suggested application for both the normal and special feeding cases.

Instruments, Apparatus, and Supplies

A. S. Aloe Company Texas representatives will be pleased to welcome their friends at booth 22. A cross section of the medical, hospital, and laboratory equipment and supplies carried by the world's largest supply house will be on display. Featured will be a large number of government surplus bargains. These items were all carefully selected by Aloe buyers and represent highest quality merchandise at savings of approximately 50 per cent.

The A. P. Cary Company in booth 46 will display a small treatment table and a few small instruments. Mr. Park Wolford will be the representative in charge.

J. E. Hanger, Inc., of Washington, D. C., with its branches, subsidiaries, and licensees is one of the oldest and largest limb manufacturers in the world. In Dallas is a fully equipped Hanger factory, where the limbs are built, fitted, and finished. Physicians are invited to visit booth 29, where models of the different limbs will be displayed, information given, and names taken of any patients whom physicians would like Hanger representatives to contact.

Tol. Higginbotham and Company, Dallas, Texas, (booth 18), will exhibit the Lit'l Tyke Trainer . . . an original by Lit'l Tyke. This scientifically designed postwar trainer is molded of washable plastic and presents an entirely new concept of toilet training. Its features include the exclusive "baby-shape" which fits the infant, affording proper support for immature muscle and bone structures, and holds him in the best functional position for quicker, easier training.

Holland-Rantos cordially invites physicians to visit booth 31, where the nationally known and universally used Koromex contraceptive specialties will be displayed. Besides the new Koromex Set Complete, which is a package combining the necessary items for complete contraceptive technique, there will be the new Nylmerate Jelly, introduced only a short time ago and received enthusiastically for the treatment of trichomoniasis and vaginal discharges of a nonspecific origin.

Representatives of the Company will be on hand to answer all questions, and samples of Nylmerate Jelly and Koromex Jelly will be available, as well as copies of the new physician's patient instruction chart.

The Karmac Company, Dallas, Texas, (booth 19) will display better plaster of Paris bandages . . . better because each bandage is rolled by hand, using the finest surgical plaster and the best crinoline. Karmac Bandages have an even distribution of plaster, soak quickly, are fast-setting, and make a strong, light-weight cast. Fewer Karmac Bandages are required to make a cast, and they come in all sizes. Visitors are invited to see the special Karmac splints.

W. A. Kyle Company, Houston, at booth 21, will display a complete line of stainless steel surgical instruments and specialized electrical equipment.

Luzier's Fine Cosmetics and Perfumes, as advertised in publications of the American Medical Association, will be on exhibit in booth 10. Mr. C. L. Rice, Texas Divisional Distributor of Luzier's Service, and officials of Luzier's, Inc., will be present. The Luzier formulas are selected to suit individual cosmetic requirements and may be modified to suit persons with allergies.

E. H. McClure Company, Dallas (booth 28), will exhibit a few pieces of examining room furniture, examining lights, office sterilizers, blood pressure instruments, surgical instruments, and physicians' bags. The booth will be in charge of Messrs. J. C. Rutledge, B. J. Marcom, and F. W. Hilliard.

The V. Mueller Company will display at booth 23 a few new surgical instruments, along with other Mueller equipment and instrument specialties. Physicians can be sure their visit to this exhibit will be worth while. Mr. Ford Dixon will be in attendance.

Pendleton & Arto, Inc., invites the doctors to visit booth 15 and see a complete line of stainless steel instruments. There physicians can learn about the large stock of equipment carried in the company warehouse for immediately delivery. Mr. W. R. McPheeters will be in charge of the booth, with the help of of Mr. D. E. Waggoner, Mr. Pat Daley, and Mr. David Hanna.

The Terrell Supply Company, Fort Worth, will display a full line of available American made stainless steel instruments, physiotherapy equipment, and examining and treatment room furniture, at booths 1 and 2. The exhibit will be attended by Messrs. O. Coffman, T. S. Curtis, and T. H. Gothard.

The United Medical Equipment Company of Kansas City, Mo., will display and demonstrate the Electro Physical Laboratories' Cardiotron at booth 45. Actual electrocardiograms will be shown on an oscilloscope as well as on the permanent scratch proof Cardiotron paper, in this latest direct recording electrocardiograph. Physicians should not fail to see this interesting exhibit.

Insurance

The Medical Protective Company, which specializes in providing protection for professional men, invites physicians to confer with its representatives at booth 16. The most exacting requirements of adequate liability protection are those of the professional liability field. Medical Protective representatives trained in professional liability underwriting.

Miscellaneous

Camel Cigarettes (booth 40 and 41) will present a dramatic full color review of their recent medical research on smoking, as well as the details of the nationwide survey showing that "More Doctors Smoke Camels Than Any Other Cigarette." Another panel will illustrate the absorption of nicotine in the respiratory tract. Representatives will be present.

Philip Morris & Company will demonstrate at booth 4 the method by which it was found that Philip Morris Cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representatives will be happy to discuss researches on this subject, and problems on the physiological effects of smoking.

Pharmaceuticals and Biologicals

Bristol Laboratories, Inc., Syracuse, N. Y., will have on display in booth 30 many of its penicillin and antibiotic products as well as a number of pharmaceutical specialties including "Alminate."

Burroughs Wellcome & Co., New York, cordially invites physicians to its exhibition of a representative group of fine pharmaceuticals and chemicals in booth 25. Of particular interest are "Nutragest," the palatable dietary compound containing the amino acids, important minerals, vitamins, and carbohydrates; Digoxin, a pure, stable, crystalline glycoside of digitalis lanata, combining uniform potency with rapidity of action; "Wellcome" Benzyl Benzoate Emulsion, the 24-hour treatment for scabies and pediculosis capita; and "Lubafax" brand surgical lubricant.

Cutter Laboratories extend an invitation to visit their technical exhibit in booth 7. On display will be the new Penicillin in Oil and Wax formula No. 3, disposable syringe. Of further interest will be the pediatric immunizing specialties and blood fractionation products.

Eaton Laboratories, Inc., (booths 34 and 35) will exhibit several pharmaceutical preparations of interest to the physician. Furacin Soluble Dressing containing a new chemotherapeutic agent, Furacin (brand of Nitrofurazone), will be exhibited. This compound is a new antibacterial agent for the treatment of wound and surface infections. Clinical evaluation throughout the past two and one-half years indicates a wide field of use.

First Texas Chemical Company of Dallas (booth 6) will display U. S. P. and N. F. products. Crude drugs as well as the finished products will be shown. Messrs. Gordon Cunningham, S. B. Miller, J. R. Rogers, and F. O. Burns will be in attendance.

Lederle Laboratories (booth 37) will display "Folvite": synthetic folic acid developed by Lederle and recommended in the treatment of macrocytic anemias of sprue, pregnancy, pellagra, and infancy; "Folvron Capsules"; Folvite, with the addition of ferrous sulfate, recommended in iron-deficient anemias; "Ledinac": a liver protein hydrolysate, plus maltose and thiamine, a valuable source of the ten essential amino acids in addition to the unessential amino acids, modified protein, vitamins, minerals, and carbohydrates in a highly palatable form; and "Benzestrol," a new synthetic estrogenic preparation offering the same results obtained by stilbestrol without the side effects of nervousness, nausea, and so forth.

The Eli Lilly and Company exhibit this year (booth 24) will feature an interesting presentation on the heart, and a discussion on cardiac drugs. Many Lilly products will be on display; representative literature will be available. The attending Lilly medical service representatives will be pleased to assist visiting physicians whenever possible.

Mead Johnson & Company will exhibit Amigen and Protolysate at booths 43 and 44 at the annual session of the State Medical Association. Mead Johnson has pioneered in the amino acid field commercially; the products have been described in more than 140 articles in the medical literature; this year they are available. Trained representatives from the Southwest will be at the Mead exhibit to discuss details of the new amino acid products. Shown also will be Dextri-Maltose, Pablum, Pabena, Oleum Percomorphum, and the other Mead products used in infant nutrition.

The Pitman-Moore display in booth 48 will feature a number of important new medical developments, including improvements in chemotherapy which minimize difficulties formerly encountered as a result of that type of medication. The exhibit will be in charge of L. W. Welch, manager of the Southwest Region, and Bernie Hayter, Dallas Medical Service representative.

The Schering Corporation (booth 36) will feature the potent oral estrogenic hormone, Estinyl (ethinyl estradiol); the oral progestin, Pranone (anhydrohydroxyprogesterone); and the oral androgen, Oreton-M (methyltestosterone). The well-known parenteral hormones, Oreton (testosterone propionate), Progynon-B (estradiol benzoate), Proluton (progesterone), and Cortate (desoxycorticosterone acetate) will also be displayed. The new effective treatment for ophthalmic infections, Sodium Sulfacetimide Solution 30% will be of interest as will the clinically safer sulfonamide combination Combisul-TD and the radiographic media Priodax and Neo-Iopax. Schering Professional Service Representatives will be present to welcome physicians and answer inquiries.

Sharp & Dohme extends a cordial welcome to all visitors at booth 27. New antibiotic preparations, including "Prothricin" nasal decongestant and "Tyroderm" tyrothricin cream, will be featured, along with sulfathalidine and sulfasuxidine, intestinal bacteriostatic agents. "Lyocyte" powder, dried human blood cells, and "Lyovac," normal human plasma, complete the items which will be on exhibit.

Smith, Kline & French Laboratories will feature Dexedrine Sulfate Tablets at booth 5. Few therapeutic agents have risen so dramatically and rapidly to preeminence as Dexedrine Sulfate. Today, its widespread clinical usefulness in depressive states and weight reduction makes this drug undeniably the central nervous stimulant of choice. Dexedrine is remarkable in that it spares the patient the disturbing consciousness of "drug stimulation," is virtually a "single action" drug, and has an extremely wide margin of safety.

Specially trained professional representatives will be glad to answer questions concerning the possible uses of Smith, Kline & French products in the practice of visiting physicians.

E. R. Squibb & Sons in booth 47 will have a display showing penicillin blood levels following administration of Crystalline Penicillin G Sodium in Oil and Wax.

U. S. Standard Products Company invites physicians to visit booth 32. Messrs. Ed Dornbach, Ed Hill, and Jack Ward, Texas representatives, will be available to give complete information on the Company's biologicals, pharmaceuticals, and hormones. Physicians should not fail to pay the booth a visit.

The Warren-Teed Laboratories' space (booth 30), easily recognized by the brilliantly-lighted, white and red display, will feature the following products: liver injection, diethylstilbestrol, pituitary (posterior) injection, ephedrine hydrochloride, aminophylline tablets, sulfathiazole tablets, riboflavin tablets, sulfanilamide, phenobarbital tablets, niacin, and nicotinamide. Mr. George T. Finney will be in charge.

Winthrop Chemical Company, Inc., New York (booth 20) extends a cordial invitation to visit its booth, where representatives will be on hand to discuss the latest therapeutic contributions made by this firm. Featured will be Aralen, new colorless antimalarial specific; Demerol, analgesic, spasmolytic, and sedative; and Digisidin, pure crystalline digitoxin, the drug of choice for routine digitalization.

X-Ray and Physiotherapy Equipment

General Electric X-Ray Corporation will have a staff of qualified, trained engineers on hand in booth 33 to greet its many friends in the State Medical Association. The representatives will be prepared to present information on General Electric's entire line of x-ray and electro-medical equipment.

The Gilbert X-Ray Company of Texas (booths 11 and 12) will welcome its friends attending the annual session. The Gilbert headquarters office and facilities are at the disposal of physicians while they are in Dallas. The company will be pleased to be of any service it can.

The Johnson X-Ray & Electro Therapy Company of Dallas presents in booths 38 and 39 the latest Mattern X-Ray Unit, the Flour-X-Ograph, a shock-proof, 100 milliampere unit, complete with motor driven tilt table, special de luxe console push button control, floor rail mounted tubestand and transformer with vapor-proof, shock-proof cables to the Aeromax double focus, oil immersed x-ray tube. Visit the Johnson booths for demonstration by Messrs. Frederic C. Johnson, Richard J. Stevenson, and Hal E. Robinson, representatives.

R. P. Kincheloe Company (booth 42) will display the new American Electric Mobile X-Ray Unit with the new tube "cartridge;" the new V Lead Simplitrol Electrocardiograph, and the new Liebel-Flar-

sheim Frequency Controlled Diathermy. Mr. A. Victor and Mr. Q. B. Schaefer will be in charge.

The Wilson X-Ray and Surgical Company (booth 26) will display the Borg 100-MA and 100-PKV fully automatic shockproof fluoroscopic and radiographic x-ray unit, which is distinctive in several features, including counter-balanced bucky, motor driven tilting table, and independently operated full sized vertical column tube stand. This unit is now available for immediate delivery.

The Wilson Company will also show the new Liebel-Flarsheim frequency controlled diathermy unit complete with patented hinged drum.

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Thirteenth District, R. G. Baker, Fort Worth (two years). H. H. Cartwright, Breckenridge, Vice-Councilor.
Fourteenth District, C. C. Nash, Dallas (two years). H. Leslie Moore, Dallas, Vice-Councilor.
Fifteenth District, C. A. Smith, Texarkana (term expires). Joe Nichols, Atlanta, Vice-Councilor.

Delegates to A. M. A.

Holman Taylor, Fort Worth (one year).
F. J. L. Blasingame, Wharton (one year).
H. R. Dudgeon, Waco (term expires).
B. E. Pickett, Sr., Carrizo Springs (term expires).
E. H. Cary, Dallas (term expires).

Alternates

R. B. Anderson,† Fort Worth (one year).
L. H. Reeves, Fort Worth (one year).
E. W. Bertner, Houston (term expires).
H. Leslie Moore, Dallas (term expires).
A. C. Scott, Temple (term expires).

Council on Medical Defense

W. D. Jones, Chairman, Dallas (one year).
Holman Taylor, Secretary (ex-officio), Fort Worth.
L. B. Jackson, San Antonio (three years).
T. R. Hannon,[1] Houston (two years).
W. L. Baugh, Lubbock (term expires).

Executive Council

Ex-officio, the President (Chairman) and the Secretary (Secretary) of the Association, President-Elect, Vice-Presidents, Board of Trustees, Board of Councilors, and the Legislative Committee.

Council on Scientific Work

Ex-officio, the President and Secretary of the Association and Officers of Scientific Sections.
A. C. Scott, Chairman, Temple (one year).
Joseph B. Copeland, San Antonio (four years).
R. B. Alexander, Waco (three years).
Vacancy[2] (two years).
Tom G. Glass, Marlin (term expires).

Council on Medical Economics

H. E. Griffin, Chairman, Graham (two years).
Tom B. Bond, Fort Worth (four years).
H. R. Dudgeon, Waco (three years).
W. R. McWilliams, Del Rio (one year).
W. F. Starley, Galveston (term expires).

Committee on Legislation

J. H. Burleson, Chairman, San Antonio (one year).
C. C. Cody, Jr. (ex-officio), Houston.
Holman Taylor, Secretary (ex-officio), Fort Worth.
L. H. Reeves, Fort Worth (four years).
J. Allen Kyle, Houston (three years).
Z. T. Scott,[3] Austin (two years).
N. D. Buie, Marlin (term expires).

Committee on Collection and Preservation of Records

W. B. Russ, Chairman, San Antonio (term expires).
E. W. Bertner, Houston (four years).
A. A. Ross,[4] Lockhart (three years).
Marvin L. Graves, Houston (two years).
John T. Moore, Houston (one year).

†Deceased March 24, 1947.
1. Appointed November 21, 1946, to fill the vacancy created by the death of Dr. K. H. Beall, Fort Worth, November 21, 1946.
2. Appointed August 1, 1946, to fill the vacancy created by the resignation August 1, 1946, of Dr. S. E. Thompson, Kerrville.
3. Appointed October 15, 1946, to fill the vacancy created by the resignation of Dr. W. B. Russ, San Antonio.
4. Appointed August 1, 1946, to fill the vacancy created by the appointment August 1, 1946, of Dr. E. A. Rowley to the Board of Trustees.
5. Appointed to fill the vacancy created by the death of Dr. J. G. Webb, Mercedes, April 17, 1946.
6. Appointed May 17, 1946, to fill the vacancy created by the resignation of Dr. J. E. Clarke, Houston.

†Deceased, January 2, 1947.
1. Appointed March 24, 1947, to fill the vacancy created by the resignation of Dr. A. P. Howard, Houston.
2. Vacancy created by the resignation of Dr. J. S. McCelvey, Temple, April 4, 1947.
3. Appointed June 24, 1946, to fill the vacancy created by the resignation of Dr. Joe Gilbert, Austin.
4. Appointed August 6, 1946, to fill the vacancy created by the death of Dr. H. W. Cummings, Hearne, July 29, 1946.

COMMITTEE ON HEALTH PROBLEMS IN EDUCATION

O. M. Marchman, Chairman, Dallas (one year).
Sam N. Key, Austin (four years).
W. S. Barcus, Fort Worth (three years).
C. P. Yeager, Corpus Christi (two years).
Allen C. Hutcheson, Houston (term expires).

COMMITTEE ON CANCER

E. W. Bertner, Chairman, Houston (one year).
David A. Todd, San Antonio (four years).
Christopher B. Carter,[1] Dallas (three years).
Frank C. Beall, Fort Worth (two years).
A. A. Ross, Jr., Lockhart (term expires).

COUNCIL ON POSTGRADUATE MEDICAL EDUCATION

David W. Carter, Jr., Chairman, Dallas (four years).
Dick P. Wall, Galveston (three years).
A. O. Singleton, Galveston (two years).
Lee Rice, San Antonio (one year).
DeWitt Neighbors, Fort Worth (term expires).

COMMITTEE ON TUBERCULOSIS

C. M. Hendricks, Chairman, El Paso (four years).
Charles J. Koerth, Junction (three years).
David McCullough, Kerrville (two years).
Howard T. Barkley, Houston (one year).
Jesse B. White, Amarillo (term expires).

COMMITTEE ON LIBRARY ENDOWMENT

V. R. Hurst, Chairman, Longview (four years).
Walter G. Stuck, San Antonio (three years).
O. B. Kiel, Wichita Falls (two years).
J. C. Terrell, Stephenville (one year).
F. T. McIntire, San Angelo (term expires).

Committee on Public Relations.—Merton M. Minter, Chairman, San Antonio; R. A. Miller, San Antonio; Allen Stewart, Lubbock; George Schenewerk, Dallas; J. E. Hogan, Big Spring; R. B. Anderson,† Fort Worth, Secretary (ex-officio).

General Arrangements Committee for Annual Session. (All of Dallas).—Frank A. Selecman, Chairman; Edwin L. Rippy, Howard K. Crutcher, John L. Goforth, C. D. Bussey.

Committee on Transportation.—W. E. Vandevere, Chairman, El Paso; Albert T. Cook, Laredo; John R. Martin, Georgetown; J. D. Nichols, Atlanta; Leroy Trice, Palestine.

Committee on Memorial Exercises.—M. D. Levy, Chairman, Houston; Sam E. Thompson, Kerrville; J. J. Crume, Amarillo; Elbert Dunlap, Dallas; J. H. Caton, Eastland.

Committee on Scientific Exhibits.—X. R. Hyde, Chairman, Fort Worth; H. L. Hilgartner, Austin; Arthur Grollman, Dallas; Stuart A. Wallace, Houston; Robert M. Moore, Galveston.

Committee on Medical Education and Hospitals.—Guy F. Witt, Chairman, Dallas; T. E. Fuller, Texarkana; C. T. Stone, Galveston; T. Wade Hedrick, Abilene; W. M. Gambrell, Austin.

Committee on Revision of Constitution and By-Laws.—President C. C. Cody, Jr., Chairman, Houston; President-Elect B. E. Pickett, Sr., Carrizo Springs; Board of Trustees, E. W. Bertner, Houston; T. C. Terrell, Fort Worth; J. B. McKnight, Sanatorium; E. A. Rowley, Amarillo; Merton M. Minter,[2] San Antonio; Secretary Holman Taylor, Fort Worth.

Advisory Committee to the Woman's Auxiliary.—Merton M. Minter, Chairman, Public Relations Committee, San Antonio, Chairman; John H. Burleson, Chairman, Legislative Committee, San Antonio; C. E. Scull, Chairman, Board of Councilors, San Antonio; E. W. Bertner, Vice-Chairman, Board of Trustees, Houston; Holman Taylor, Secretary, Fort Worth.

Advisory Board to the Texas Society of Medical Technologists.—S. W. Bohls, Chairman, Austin; J. L. Goforth, Dallas; W. N. Powell, Temple.

Committee on Mental Health.—Charles W. Castner, Chairman, Austin; Arthur J. Schwenkenberg, Dallas; Titus H. Harris, Galveston; Melbourne J. Cooper, San Antonio; Roy C. Sloan, Terrell.

Committee on Maternal and Child Health.—Allen Stewart, Chairman, Lubbock; Frank Lancaster, Houston; Milton Davison, Marlin; Arild Hansen, Galveston; Robert A. Johnston, Houston; T. J. McElhenney, Austin.

Committee on Venereal Diseases.—Thomas M. Jarmon, Chairman, Tyler; C. F. Lehmann, San Antonio; W. S. Wysong, McKinney; H. B. Allen, Brownwood; S. B. Tucker, Nacogdoches.

Committee on Industrial Health.—H. F. Poyner, Chairman, Houston; Carl A. Nau, Galveston; F. L. Snyder, Fort Worth; L. C. Heare, Port Arthur; Sam C. Arnett, Lubbock.

Committee on Military Affairs.—Holman Taylor, Chairman, Fort Worth; R. B. Anderson,† Vice Chairman, Fort Worth; G. F. Thornhill, Austin; E. F. Cadenhead, Brownwood; C. G. Swift, Cameron; J. S. McCelvey, Temple.

Committee on Nurses Shortage.—J. F. McVeigh, Chairman, Fort Worth; George A. Schenewerk, Dallas; G. E. Brereton, Dallas; Tom Bond, Fort Worth; A. C. Scott, Temple; Frank Hodges, Abilene; J. D. Hall, Wichita Falls.

Advisory Council of Past Presidents.—All of the Past Presidents of the State Medical Association.

SPECIAL DELEGATES

Texas Hospital Association.—L. L. D. Tuttle, Houston.

Texas State Nutrition Council.—LeRoy B. Duggan, Houston.

OFFICERS OF SCIENTIFIC SECTIONS

SECTION ON MEDICINE

James A. Greene, Chairman, Houston.
Raymond Gregory, Secretary, Galveston.

SECTION ON SURGERY

Walter G. Stuck, Chairman, San Antonio.
Cornelius Olcott, Secretary, Harlingen.

SECTION ON OBSTETRICS AND GYNECOLOGY

G. H. Beavers, Jr., Chairman, Fort Worth.
William P. Devereux, Secretary, Dallas.

SECTION ON EYE, EAR, NOSE, AND THROAT

R. E. Parrish, Chairman, San Antonio.
Oscar Marchman, Jr., Secretary, Dallas.

SECTION ON RADIOLOGY AND PHYSIOTHERAPY

L. M. Garrett, Chairman, Corpus Christi.
H. E. Whigham, Secretary, McAllen.

SECTION ON PUBLIC HEALTH

Elliott Mendenhall, Chairman, Dallas.
B. M. Primer, Secretary, Austin.

SECTION ON CLINICAL PATHOLOGY

Charles Phillips, Chairman, Temple.
Ellen D. Furey, Secretary, Beaumont.

SECTION ON PEDIATRICS

J. H. Park, Jr., Chairman, Houston.
Harold T. Nesbit, Secretary, Dallas.

LOCAL COMMITTEES

General Arrangements.—Frank A. Selecman, Chairman; Edwin L. Rippy, Howard K. Crutcher, John L. Goforth, and C. D. Bussey.

†Deceased January 2, 1947.

†Deceased, January 2, 1947.

1. Appointed February 24, 1947, to fill the vacancy created by the death of Dr. George T. Caldwell, Dallas, January 20, 1947.

2. Appointed October 15, 1946, to fill the vacancy created by the resignation of Dr. W. B. Russ, San Antonio.

Hotels.—Jack G. Kerr, Chairman; Murphy Bounds, Jo C. Alexander, Glenn D. Carlson, Alvin Baldwin, and Andrew Small.

Information.—Ramsay Moore, Chairman; Ben R. Buford, C. Frank Brown, Casey E. Patterson, L. M. Reaves, Taylor T. Pickett, William M. Lively, Jr., and Thomas S. Love.

Finance.—Davis Spangler, Chairman; F. J. Sebastian, Floyd Norman, Gordon Maddox, Samuel A. Shelburne, C. J. Paternostro, J. R. Maxfield, Floyd Franklin, and Ruth Jackson.

Memorial.—Elliott Mendenhall, Chairman; Nina Fay Calhoun, Milford O. Rouse, O. W. Gibbons, and L. C. Sams.

Clinical Luncheons.—Thomas E. Smith, Chairman; Robert L. Moore, John S. Bagwell, Robert Sparkman, James H. Herndon, Charles LaDue, J. G. Brau, S. A. Alexander, Morton L. Mazer, Ridings E. Lee, Cecil Stell, and M. M. Scurry.

Alumni Banquets.—Tate Miller, Chairman; Paul J. Thomas, Thomas Barr, Charles Duncan, and J. Hudson Dunlap.

Reception.—Everett C. Fox, Chairman; Edward White, Lee Hudson, A. R. Thomasson, Paul Williams, Henry M. Winans, H. Leslie Moore, Brandon Carrell, G. D. Mahon, W. L. Hart, Arthur Grollman, Lyle M. Sellers, Oscar M. Marchman, Sr., John Young, David Carter, G. E. Brereton, Guy T. Denton, Sr., Homer Donald, Curtice Rosser, Charles Martin, Marvin Bell, J. N. McLeod, Wayne T. Robinson, Elbert Dunlap, C. C. Nash, E. S. Gordon, Rufus Whitis, W. D. Jones, E. H. Cary, Minnie L. Maffett, Guy Witt, R. E. Van Duzen, and J. W. Bourland.

Entertainment.—Hall Shannon, Chairman; Dayton McBride, Halcuit Moore, Ruby Daniel, Louie Allday, M. K. McCullough, John L. Jenkins, John McLaurin, O. R. Caillet, Wallace Wilkinson, Hubert Hawkins, Archibald McNeill, and John Pace.

Golf.—H. A. O'Brien, Chairman; Robert B. Giles, S. M. Hill, J. H. McCracken, R. B. McBride, Robert M. Barton, and Kelly Cox.

Skeet and Trap Shoot.—Arthur Schoch.

Transportation.—T. M. Kirksey, Chairman; Richard A. Dathe, Raymond Willis, Sidney Galt, and Dudley P. Laugenour.

Scientific Exhibits.—John E. Ashby, Chairman; Howard E. Heyer, Charles T. Ashworth, Bruce A. Knickerbocker, Maxwell Thomas, Penn Riddle, Lawrence Sheldon, Barton Park, Dudley Singleton, Ben A. Merrick, and Merritt B. Whitten.

Technical Exhibits.—J. Howard Shane, Chairman; John Chapman, Walton Cochran, Sydney Baird, William P. Devereux, and William Fuqua.

Halls and Lanterns.—Guy T. Denton, Jr., Chairman; H. M. Spence, T. W. Bywaters, Felix Butte, Robert Carpenter, and A. M. Reagan.

Public Lectures.—J. H. Black Chairman; W. Grady Reddick, Tinsley R. Harrison, Percy M. Girard, Gaston Harrison, J. W. Duckett, Cecil O. Patterson, and May Agness Hopkins.

Publicity.—George A. Schenewerk, Chairman; Robert Short, Alexander Terrell, G. Raworth Williams, Watt Winn, Harold Clark, and W. K. Strother.

Guest Sponsors
(All from Dallas)

For Dr. Herbert D. Adams.—J. W. Duckett.
For Dr. Joseph M. Donald.—J. Howard Shane.
For Dr. Harold O. Jones.—William F. Mengert.
For Dr. R. H. Kampmeier.—Henry Winans.
For Dr. Thomas B. Magath.—J. L. Goforth.
For Dr. William L. Mann.—Grady Reddick.
For Dr. Waldo E. Nelson.—H. Leslie Moore.
For Dr. Walter L. Palmer.—Sam Shelburne.
For Dr. John J. Shea.—John McLaurin.
For Dr. Harrison H. Shoulders.—Edward H. Cary.
For Dr. Wilson G. Smillie.—J. W. Bass.
For Dr. Harry M. Weber.—Davis Spangler.

HOUSE OF DELEGATES
First Meeting, Monday, May 5, 10:00 a. m.
Roof Garden, Fifteenth Floor, Hotel Adolphus

1. Call to Order.
2. Roll Call and Announcement of Result.
3. Reading of Minutes of Previous Meeting.
4. Appointment of Reference Committees.
5. Report of Secretary.
6. Report of Treasurer.
7. Report of Board of Trustees.
8. Report of Board of Councilors.
9. Report of Council on Medical Defense.
10. Report of Executive Council.
11. Report of Council on Scientific Work.
12. Report of Council on Medical Economics.
13. Council on Postgraduate Medical Education.
14. Report of Standing Committees:
    - Committee on Legislation.
    - Committee on Public Relations.
    - Committee on Library Endowment.
    - Committee on Collection and Preservation of Records.
    - Committee on Health Problems in Education.
    - Committee on Cancer.
    - Committee on Tuberculosis.
    - Committee on Transportation.
    - Committee on Arrangements for the Annual Session.
    - Committee on Memorial Exercises.
15. Report of Special Committees:
    - Committee on Scientific Exhibits.
    - Committee on Medical Education and Hospitals.
    - Committee on Revision of Constitution and By-Laws.
    - Advisory Committee to the Woman's Auxiliary.
    - Committee on Mental Health.
    - Committee on Military Affairs.
    - Committee on Maternal and Child Health.
    - Advisory Board to the Texas Society of Medical Technologists.
    - Committee on Venereal Diseases.
    - Committee on Industrial Health.
    - Committee on Medical Licensure.
    - Committee on Nurses Shortage.
    - Advisory Council of Past Presidents.
16. Reports of Special Delegates.
    - Texas Hospital Association.
    - Texas State Nutrition Council.
17. Presentation of Fraternal Delegates.
18. Report of Special Committees of the House.
19. Reading of Communications.
20. Reading of Memorials and Resolutions.
21. Unfinished Business.
22. New Business.
23. Reports of Reference Committees:
    - (1) Reference Committee on Credentials.
    - (2) Reference Committee on Reports of Officers and Committees.
    - (3) Reference Committee on Resolutions and Memorials.
    - (4) Reference Committee on Finance.
    - (5) Reference Committee on Amendments to Constitution and By-Laws.
    - (6) Reference Committee on Scientific Work.
    - (7) Reference Committee on Medical Service and Public Relations.
    - (8) Board of Councilors.
    - (9) Board of Trustees.
24. Election of Officers (morning of last day):
    - President-Elect.
    - Three Vice-Presidents.
    - Secretary (Expiration term Holman Taylor).
    - Treasurer (Expiration term T. H. Thomason).
    - One Trustee (Expiration term E. W. Bertner, elected first term 1941).

Five Councilors (Expiration terms Harvey H. Latson, 3rd Dist., appointed to fill unexpired term 1946; C. E. Scull, 5th Dist., served three three-year terms; W. E. Whigham, 6th Dist., appointed to fill unexpired term April, 1946; G. V. Brindley, 12th Dist., elected first term 1943; C. A. Smith, 15th Dist., appointed to fill unexpired term 1939—Nomination by district societies, at their regular meetings, or in the instance no such society exists or is in a position to so nominate, by a majority vote of the elected delegates of county societies from the district concerned.)

Three Delegates to A. M. A. (Expiration terms H. R. Dudgeon, B. E. Pickett, Sr., and E. H. Cary).

Three Alternate Delegates to A. M. A. (Expiration terms E. W. Bertner, H. Leslie Moore, and A. C. Scott).

Member, Council on Medical Defense (Expiration term W. L. Baugh, served two four-year terms).

Member, Council on Scientific Work (Expiration term Tom G. Glass, elected first term 1941—Nomination by President-Elect).

Member, Council on Medical Economics (Expiration term W. F. Starley, served two five-year terms — Nomination by President-Elect).

Member, Committee on Legislation (Expiration term N. D. Buie, appointed to fill unexpired term 1941—Nomination by President-Elect).

Member, Committee on Collection and Preservation of Records (Expiration term W. B. Russ, served two five-year terms—Nomination by Retiring President, upon advice of Past-Presidents' Association).

Member, Committee on Health Problems in Education (Expiration term Allen C. Hutcheson, appointed to fill unexpired term 1946—Nomination by President-Elect).

Member, Committee on Cancer (Expiration term A. A. Ross, Jr., served two five-year terms—Nomination by President-Elect).

Member, Council on Postgraduate Medical Education (Expiration term DeWitt Neighbors, elected first term 1941—Nomination by President-Elect).

Member, Committee on Tuberculosis (Expiration term Jesse B. White, appointed first term 1946—Appointment by President-Elect with confirmation by House of Delegates).

Member, Committee on Library Endowment (Expiration term F. T. McIntire, appointed first term 1946—Appointment by President-Elect with confirmation by House of Delegates).

25. Selection of Time and Place of Next Annual Session.

RELATED ORGANIZATIONS

TEXAS RAILWAY AND TRAUMATIC SURGICAL ASSOCIATION

Monday, May 5, 9:00 a. m.

Ballroom, Lobby Floor, Hotel Adolphus

President—F. L. Snyder, Fort Worth.

First Vice-President—Linwood H. Denman, Lufkin.

Second Vice-President—Denman C. Hucherson, Houston.

Secretary-Treasurer—Ross Trigg, Fort Worth.

1. *President's Address: Progress and Trend of Surgery of the Large Bowel.*
F. L. Snyder, Fort Worth.
2. *Surgery of the Common Bile Duct.*
John Phillips, Houston.
3. *Management of Fractures About the Ankle Joint.*
Frank McGehee, Houston.
4. *Refrigeration Anesthesia in Traumatic Surgery.*
Joe R. Gandy, Houston.
5. *The Future of Our Coronary Patients.*
L. H. Reeves, Fort Worth.
6. *The Industrial Back.*
Y. C. Smith, Corpus Christi.
7. *Herniation of Fascial Fat, A Cause of Low Back Pain.*
Denman C. Hucherson, Houston.
8. *The Low Back Problem.*
Sim Driver, *Dallas.*
9. *Plastic Repair of Burn Scars* (Lantern Slides).
A. D. Roberts, Fort Worth.
10. *Business Session.*
11. *Election of Officers.*
12. *Barbecue for Members.*

TEXAS STATE HEART ASSOCIATION

Monday, May 5, 9:15 a. m.

North Room, Fifteenth Floor, Hotel Adolphus

President—Robert M. Barton, Dallas.

Vice-President—Hatch W. Cummings, Jr., Houston.

Secretary-Treasurer—Merritt B. Whitten, Dallas.

(Essayists are requested to allow time for discussion if possible).

1. (9:15) *Changes in Circulation in Heat Stroke: An Experimental Study in Animals.*
William M. Daily and Tinsley Harrison, Dallas.
(Presented by Dr. Daily).
2. (9:50) *Allergic Cardiovascular Diseases.*
Norman D. Schofield and Milton R. Hejtmancik, Galveston.
(Presented by Dr. Schofield).
3. (10:25) *Paroxysmal Ventricular Tachycardia, with Reference to Treatment.*
Milton R. Hejtmancik and George R. Herrmann, Galveston.
(Presented by Dr. Hejtmancik).
4. (11:00) *Clinical Significance of the Precordial Electrocardiogram with Special Reference to Interpretation of the QRS Complexes.*
Carl F. Shaffer, Houston.
5. (11:35) *Rheumatic Fever.*
David R. Sacks, *San Antonio.*
6. (12:20) *Luncheon and Business Meeting.*
Robert M. Barton, Dallas, presiding.
7. (2:30) *Hypertension.*
Arthur Grollman, Dallas.
8. (3:00) *Newer Concept of Stokes-Adams Syndrome.*
Sidney Schnur, Houston.
9. (3:30) *Alterations in Form of the Electrocardiogram in Patients with Mental Disease.*
Howard E. Heyer, Henry M. Winans, and Virgil I. Plessinger, Dallas.
(Presented by Dr. Heyer).
10. (4:00) *Hyperventilation Syndrome.*
Alfred Harris, Dallas.

TEXAS NEUROPSYCHIATRIC ASSOCIATION

Monday, May 5, 9:30 a. m.
Room 4, Mezzanine Floor, Baker Hotel

President—FRED T. ROGERS, Dallas.
Vice-President—JACK EWALT, Galveston.
Secretary-Treasurer—DAVID WADE, Austin.

1. *Business Session* (important).
2. *Barbiturate Addiction.* E. L. ATEN, Dallas.
3. *Lindau's Disease.* PAUL LEVIN, Dallas.
4. *Acute Infections of the Meninges.* GRADY REDDICK and HOWARD REID, Dallas.
5. *Treatment of Neurosyphilis As of the Year 1947.* HARRY C. SOLOMON, Boston, Mass. (guest speaker).
6. *Lunch.*
7. *Narco-Analysis and Narcosynthesis.* PERRY C. TALKINGTON, Dallas.
8. *Exhaustion Delirium.* S. D. VESTERMARK, Fort Worth.
9. *Metrazol: Its Current Use.* E. C. WINKELMAN, Dallas.
10. *Selection of Cases for Shock Therapy.* J. C. STURGELL, Fort Worth.
11. *Follow-Up Study of 700 Discharged Navy and Marine Psychotic Patients.* T. W. MCDANIEL, Fort Worth.
12. *Experience with Bilateral Prefrontal Lobotomy in the Psychoses.* HARRY C. SOLOMON, Boston, Mass.
13. *Business Session and Election of Officers.*
14. (7:00) *Dinner.*
15. *Symposium: The Care of Psychotic Patients.* HARRY C. SOLOMON, Boston, Mass.; W. F. OSSENFORT, Fort Worth; JACK EWALT, Galveston; A. D. PATTILLO, Terrell; CHARLES CASTNER, Austin.

Members of the association are invited to the U. S. Public Health Service Hospital, Fort Worth, at 10:00 a. m., Tuesday, May 6, for a clinic demonstrating shock therapy and electro-encephalography with clinical cases and a discussion of the problems of drug addiction.

TEXAS SOCIETY OF GASTROENTEROLOGISTS AND PROCTOLOGISTS

Monday, May 5, 9:30 a. m.
Room 3, Mezzanine Floor, Baker Hotel

President—TOM E. SMITH, Dallas.
Vice-President—GEORGE M. UNDERWOOD, Dallas.
Vice-President—HUGH BEATON, Fort Worth.
Secretary-Treasurer—DOLPH L. CURB, Houston.

1. (9:30) *Evaluation of Endoscopic Aids in the Diagnosis of Gastric Malignancy.* CECIL O. PATTERSON, Dallas.
2. (10:00) *Present Status of the Problem of Gastric Malignancies.* R. LEE CLARK, JR., Director, M. D. Anderson Hospital for Cancer Research, Houston.
3. (10:30) *Discussion.*
4. (11:00) *Diagnosis of Carcinoma of the Colon and Rectum.* CARL GIESECKE, San Antonio.
5. (11:30) *Treatment of Carcinoma of the Colon and Rectum.* HARRY BURR, Houston.
6. (12:00) *Discussion.*

8:00 p. m.
Room 6, Mezzanine Floor, Baker Hotel

7. *Dinner.*
(Ladies and other guests are invited.)

TEXAS ASSOCIATION OF MEDICAL ANESTHETISTS

Monday, May 5, 2:00 p. m.
Parlor E, Sixth Floor, Hotel Adolphus

President—CLAUDIA POTTER, Temple.
President-Elect—ROBERT A. MILLER, San Antonio.
Vice-President—J. CLINTON YOUNGBLOOD, Houston.
Secretary-Treasurer—RUSSELL F. BONHAM, Houston.

1. (2:00) *President's Address.* CLAUDIA POTTER, Temple.
2. (2:30) *Experiences with Anesthesia for Cardiac Surgery.* L. F. SCHUHMACHER, JR., Houston.
   (2:50) Discussion.
3. (3:00) *Anesthesia for Upper Abdominal Surgery.* FRED E. WOODSON, Tulsa, Okla.
   (3:20) Discussion.
4. (3:30) *The Role of the Anesthesiologist in the Care of the Patient.* URBAN H. EVERSOLE, Chief Anesthesiologist, Lahey Clinic, Boston, Mass.
   (4:15) Discussion.
5. (4:30) *Procaine Content of the Cerebrospinal Fluid During Spinal Anesthesia.* F. A. DUNCAN ALEXANDER, McKinney.
   (4:50) Discussion to be opened by John W. Winter, San Antonio.
6. (5:00) *Circulatory and Respiratory Distress from Extreme Position on the Operating Table.* C. R. ALLEN and HARVEY C. SLOCUM, Galveston.
   (5:20) Discussion.
   (5:30) Intermission.
7. (5:40) *Motion Pictures: "Vinethene"* (Merck and Co.) and *"Continuous Spinal Anesthesia in Cesarean Section."*
8. (6:30) *Business Session.*
9. (7:15) *Cocktail Hour.*

TEXAS CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

Monday, May 5, 10:00 a. m.
Rooms 5 and 6, Mezzanine Floor, Baker Hotel

President—R. G. MCCORKLE, San Antonio (presiding).
First Vice-President—H. FRANK CARMAN, Dallas.
Second Vice-President—ROBERT B. HOMAN, El Paso.
Secretary-Treasurer—ELLIOTT MENDENHALL, Dallas.
(Opening discussions limited to five minutes. Other discussions limited to three minutes.)

10:00 a. m.—Medical

1. *Pulmonary Cavitation—Some Diagnostic Problems.*
   WALTER C. BROWN, M. D., Corpus Christi.
   Discussion to be opened by H. FRANK CARMAN, Dallas.
2. *Pulmonary Infarction.*
   JOHN CHAPMAN, Dallas.
   Discussion to be opened by H. FRANK CARMAN, Dallas.
3. *Skin Sensitivities Correlated with Lung Radiopathies.*
   RAY BOSTER, Sanatorium, and VICTOR E. SCHULZE, San Angelo.
   Discussion to be opened by DAVID MCCULLOUGH, Kerrville.
4. *Tuberculosis Among Workers in Dusty Trades.*
   CARL A. NAU, Galveston.
   Discussion to be opened by HENRY R. HOSKINS, San Antonio.
5. *Pulmonary Embolism.*
   JOHN A. WIGGINS, JR., Fort Worth.
   Discussion to to opened by ELLIOTT MENDENHALL, Dallas.

Recess.

(Nominating and Executive Committees will convene during recess.)

2:00 p. m.—Surgical

6. *A Stab Wound of the Heart—A Case Report.*
   EDWARD W. COYLE, San Antonio.
   Discussion to be opened by ROBERT B. HOMAN, JR., El Paso.
7. *Thoracoplasty—Report of Results of a Consecutive Series.*
   ROBERT B. HOMAN, JR., El Paso.
   Discussion to be opened by JOHN ROBERTS PHILLIPS, Houston.
8. *Mediastinal Tumors.*
   JOHN ROBERTS PHILLIPS, Houston.
   Discussion to be opened by THOMAS JONES, Houston.
9. *Transthoracic Gastric and Esophageal Resections with Anastomosis.*
   JAMES E. DAILEY and HOWARD T. BARKLEY, Houston.
   Discussion to be opened by ROBERT SHAW, Dallas.

6:30 p. m.

10. *Banquet.*
    Report by President of Texas Chapter of Its Activities and Accomplishments in 1946-1947 and the State of the Tuberculosis Problem in Texas.
    R. G. MCCORKLE, San Antonio.
    Introduction of CHARLES M. HENDRICKS, El Paso, President, American College of Chest Physicians.
    Chest Surgery in the Tuberculous Negro.
    DAVID HARVEY SHIPP, Little Rock, Ark.
    Business Session and Election of Officers.

CONFERENCE OF CITY AND COUNTY HEALTH OFFICERS

Monday, May 5, 8:00 a. m.

Danish Room, Fifteenth Floor, Hotel Adolphus

O. B. KIEL, Wichita Falls, Member of Texas State Board of Health, Presiding.

1. *Annual Address of State Health Officer.*
   GEORGE W. COX, Austin.
2. *Subject to be announced.*
   WILSON G. SMILLIE, Cornell University Medical College, New York, N. Y.
3. *Tuberculosis Control in Texas.*
   H. E. SMITH, Austin.
4. *Venereal Disease Control.*
   R. S. LLOYD, Austin.
5. *Maternal and Child Health.*
   CARL F. MOORE, JR., Austin.
6. *State Laboratory Services.*
   J. V. IRONS, SC.D., Austin.
7. *Hospital Survey and Construction Program in Texas.*
   MR. NORMAN B. ROBERTS, Austin.

Announcements and Program

of the

TWENTY-NINTH ANNUAL SESSION

of the

WOMAN'S AUXILIARY TO THE STATE MEDICAL ASSOCIATION OF TEXAS

May 5, 6, 7, and 8, 1947
DALLAS, TEXAS

OFFICERS

Honorary Life Presidents—Mrs. A. C. Scott, Temple; Mrs. Frank Haggard, San Antonio; Mrs. M. L. Graves, Houston; Mrs. W. A. Wood, Waco.

President—Mrs. George Turner, El Paso.

President-Elect—Mrs. E. C. Ferguson, Beaumont.

First Vice-President—Mrs. L. B. Windham, Tyler.

Second Vice-President—Mrs. V. M. Longmire, Temple.

Third Vice-President—Mrs. R. E. Clark, Memphis.

Fourth Vice-President—Mrs. J. E. Hogan, Big Spring.

Corresponding Secretary—Mrs. Robert F. Thompson, El Paso.

Recording Secretary—Mrs. M. A. Ramsdell, San Antonio.

Publicity Secretary—Mrs. J. F. Campbell, Fort Worth.

Treasurer—Mrs. J. Guy Jones, Dallas.

Parliamentarian—Mrs. Joe D. Nichols, Atlanta.

STANDING COMMITTEES

Legislation—Mrs. A. B. Pumphrey, Fort Worth.

Public Relations—Mrs. Joe B. Foster, Houston.

Library—Mrs. H. P Ledford, Wichita Falls, Chairman; Mrs. J. H. McCracken, Dallas; Mrs. J. R. Winston, Temple; Mrs. John Crockett, Austin.

Historian—Mrs. E. H. Marek, Yoakum.

Student Loan Fund—Mrs. M. L. Graves, Chairman, Houston; Mrs. Willard Cooke, Galveston; Mrs. John T. Moore,† Houston.

George Plunkett Red Fund—Mrs. W. E. Ramsay, Chairman, Houston; Mrs. J. A. Watts, San Antonio.

Memorial Fund—Mrs. O. M. Marchman, Chairman, Dallas; Mrs. Joe B. Foster, Houston; Mrs. S. F. Harrington, Dallas.

Resolutions—Mrs. Marvin Duckworth, Chairman, Cuero; Mrs. J. C. Terrell, Stephenville.

†Deceased February 21, 1947.

Revisions—Mrs. J. Frank Clark, Chairman, Georgetown; Mrs. Ramsay Moore, Dallas; Mrs. Troy Shafer, Harlingen.

Reference—Mrs. Mark H. Latimer, Chairman, Houston; Mrs. William Hibbitts, Texarkana.

Exhibits—Mrs. J. L. Jinkins, Chairman, Galveston; Mrs. P. R. Denman, Houston; Mrs. Charles L. Martin, Dallas; Mrs. Ramsay Moore, Dallas.

Archives—Mrs. W. A. Wood, Chairman, Waco; Mrs. Thomas Jarmon, Tyler; Mrs. Frank W. Armstrong, Fort Worth.

Research to Southern Medical Association—Mrs. E. W. Coyle, San Antonio.

Bulletin—Mrs. William Janssen, Corpus Christi.

Memorial Service—Mrs. W. R. Thompson, Chairman, Fort Worth; Mrs. John T. Moore,† Houston; Mrs. O. R. Grogan, Fort Worth.

Budget and Finance—Mrs. S. M. Hill, Chairman, Dallas; Mrs. F. R. Rugeley, Wharton; Mrs. S. H. Watson, Waxahachie.

Nominations—Mrs. C. B. Alexander, Chairman, San Antonio; Mrs. Scott Applewhite, San Antonio; Mrs. P. R. Denman, Houston; Mrs. H. S. Renshaw, Fort Worth; Mrs. Fred Sutton, Beaumont; Mrs. August Streit, Amarillo, Mrs. Leslie Moore, Dallas.

Advisory—Mrs. C. B. Alexander, Chairman, San Antonio; Mrs. Sam Thompson, Kerrville; Mrs. A. B. Pumphrey, Fort Worth; Mrs. P. R. Denman, Houston; Mrs. S. F. Harrington, Dallas; Mrs. William Hibbitts, Texarkana; Mrs. Scott Applewhite, San Antonio.

Special Advisory—Mrs. E. V. DePew, Chairman, San Antonio; Mrs. S. H. Watson, Waxahachie; Mrs. F. F. Kirby, Waco; Mrs. Frank Haggard, San Antonio; Mrs. G. V. Brindley, Temple; Mrs. H. R. Dudgeon, Waco; Mrs. E. H. Cary, Dallas; Mrs. O. M. Marchman, Dallas; Mrs. H. C. Haden, Houston; Mrs. Joe Gilbert, Austin; Mrs. H. B. Trigg, Fort Worth; Mrs. S. A. Collom, Texarkana; Mrs. W. A. Wood, Waco; Mrs. M. L. Graves, Houston; Mrs. W. R. Thompson, Fort Worth.

School of Instruction—Mrs. Frank Haggard, San Antonio.

Council Women

District 1—Mrs. A. D. Long, El Paso.
District 2—Mrs. A. J. Cooper, Midland.
District 3—Mrs. W. R. Klingensmith, Amarillo.
District 4—Mrs. D. W. Jordan, Brady.
District 5—Mrs. H. H. Gallatin, Kerrville.
District 6—Mrs. P. H. Frenzel, Donna.
District 7—Mrs. T. J. McElhenney, Austin.
District 8—Mrs. F. J. L. Blasingame, Wharton.
District 9—Mrs. Jesse B. Johnson, Galveston.
District 10—Mrs. John Carter, Beaumont.
District 11—Mrs. George Hilliard, Jacksonville.
District 12—Mrs. G. V. Brindley, Temple.
District 13—Mrs. A. W. Brazda, Ranger.
District 14—Mrs. O. W. Robinson, Paris.
District 15—Mrs. R. C. Cross, Texarkana.

Local Convention Chairmen

General Arrangements—Mrs. J. Forest Buchanan.
Registration—Mrs. Earl L. Loftis.
Courtesy—Mrs. Jack G. Kerr.
Decorations—Mrs. L. S. Thompson.
Publicity—Mrs. Ben F. Harrison.
Transportation—Mrs. Earl L. Carter.
Exhibits—Mrs. S. M. Hill.
General Chairman of Hostesses—Mrs. Ridings E. Lee.

†Deceased February 21, 1947.

Executive Board Luncheon Hostess—Mrs. J. Guy Jones.

Past Presidents' Dinner Hostesses—Mrs. S. F. Harrington, Chairman, Dallas; Mrs. O. M. Marchman, Dallas; Mrs. Edward H. Cary, Dallas; Mrs. S. H. Watson, Waxahachie; Mrs. P. R. Denman, Houston.

Council Women's Luncheon Hostess—Mrs. Cecil O. Patterson.

County Presidents and Program Chairmen Luncheon Hostesses—Mrs. J. Forest Buchanan and Mrs. John M. Pace.

Tea Hostess—Mrs. Hall Shannon.

No-Host Auxiliary Luncheon, Chairman—Mrs. J. L. Goforth.

Memorial Service, Hostess—Mrs. H. Leslie Moore.

Post Executive Board Meeting, Hostess—Mrs. John M. Pace.

Tickets to all functions may be obtained upon registration.

Monday, May 5

9:00 a. m.-5:00 p. m. Registration and Open House, Mezzanine Floor, Baker Hotel. Mrs. Earl L. Loftis, Chairman of Registration, and Mrs. Ridings E. Lee, Chairman of Hostesses.

11:00 a. m. Preconvention Meetings of the Library Fund, Student Loan Fund, George Plunkett Red Fund, Memorial Fund, and Nominations Committees, Mezzanine Floor, Baker Hotel.

1:00 p. m. State Executive Board Luncheon, Lounge, Baker Hotel. President, Mrs. George Turner, El Paso, presiding, and Mrs. J. Guy Jones, Hostess.

Invocation—Mrs. S. H. Watson, Waxahachie.

Address of Welcome—Mrs. J. Forest Buchanan, President, Dallas Auxiliary.

Response—Mrs. William Hibbitts, Texarkana.

Presentation of Past Presidents—Mrs. G. V. Brindley, Temple.

Message from President-Elect—Mrs. E. C. Ferguson, Beaumont.

Address—Dr. Merton M. Minter, San Antonio, Chairman, Public Relations Committee, State Medical Association.

Recommendations from Officers and Chairmen of Standing Committees.

7:00 p. m. Past Presidents' Dinner, Dallas Woman's Club. Hostesses, Mrs. S. F. Harrington, Dallas, Chairman; Mrs. Edward H. Cary, Dallas; Mrs. O. M. Marchman, Dallas; Mrs. P. R. Denman, Houston; Mrs. S. H. Watson, Waxahachie.

Tuesday, May 6

9:00 a. m. Opening Exercises of State Medical Association, Ballroom, Lobby Floor, Hotel Adolphus.

11:00 a. m. First Business Session of Woman's Auxiliary to the State Medical Association, Peacock Terrace, Baker Hotel. President, Mrs. George Turner, El Paso, presiding.

Invocation—Mrs. P. R. Denman, Houston.

Address of Welcome—Mrs. John M. Pace, President-Elect, Dallas Auxiliary.

Response—Mrs. Dan Russell, San Antonio.

Address—Dr. Claude C. Cody, Jr., Houston, President, State Medical Association.

Reports of State Officers and Committee Chairmen.

1:00 p. m. School of Instruction Luncheons, Crystal Ballroom, Baker Hotel. Mrs. Frank Haggard, San Antonio, General Chairman.

1. Council Women's Luncheon, No-Host. Mrs. L. B. Windham, Tyler, Leader of Round-Table Discussion, assisted by Mrs. O. B. Robinson, Paris.
2. County Presidents and Program Chairmen Luncheon, No-Host. Mrs. Frank Haggard, San Antonio, Leader of Round-Table Discussion, assisted by Mrs. Charles B. Alexander, San Antonio; Mrs. J. E. Hogan, Big Spring; Mrs. Joe B. Foster, Houston.
3. All other State Officers and Chairmen are requested to arrange no-host luncheons or conferences with corresponding County officers and Chairmen.

3:00-5:00 p. m. Tea honoring the State President, Mrs. George Turner, El Paso; President-Elect, Mrs. E. C. Ferguson, Beaumont; all members of the Auxiliary; and all visiting ladies, Dallas Woman's Club. Compliments of the Dallas Auxiliary.

9:15 p. m. Reception and Ball honoring Dr. Claude C. Cody, Jr., Houston, President of the State Medical Association, Crystal Ballroom, Baker Hotel.

Wednesday, May 7

9:00 a. m. Second Business Session of the Auxiliary, Peacock Terrace, Baker Hotel.

Report of Council Women and County Presidents.

1:00 p. m. No-Host Luncheon for all Members and Visiting Ladies, Mural Room, Baker Hotel. Style Show, compliments of Neiman-Marcus.

Invocation—Mrs. M. H. Crabb, Fort Worth.

Address: The Heart and How to Care for It.—Dr. Ralph H. Homan, F. A. C. P., El Paso, Councilor, District 1, State Medical Association.

Auxiliary Awards—Mrs. E. H. Marek, Yoakum, Historian.

Report of Resolutions Committee—Mrs. Marvin Duckworth. Cuero.

Election and Installation of Officers—Mrs. S. F. Harrington, Dallas, Chairman of Installations.

Acceptance of Gavel—Mrs. E. C. Ferguson, Beaumont.

4:45 p. m. Memorial Services of the State Medical Association and the Woman's Auxiliary, Ballroom, Hotel Adolphus. Dr. M. D. Levy, Houston, State Medical Association, Chairman; Mrs. W. R. Thompson, Fort Worth, Auxiliary Chairman.

6:30-9:00 p. m. Buffet Supper and Dance, The Plantation, 6400 Harry Hines Boulevard. Dr. Hall Shannon, Chairman; compliments of the Dallas County Medical Society.

Thursday, May 8

9:00 a. m. Post Executive Board Meeting, Room 1, Baker Hotel. Mrs. E. C. Ferguson, President, presiding.

MISCELLANEOUS

COMING MEETINGS AND CLINICS

State Medical Association of Texas, Dallas, May 5-8, 1947. Dr. C. C. Cody, Jr., Houston, President; Dr. Holman Taylor, 1404 W. El Paso St., Fort Worth 3, Secretary.

American Medical Association, Atlantic City, N. J., June 9-13, 1947. Dr. Harrison H. Shoulders, Nashville, Tenn., President; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secretary.

Southern Medical Association, November, 1947. Dr. E. L. Henderson, Louisville, Ky., President; C. P. Loranz, Empire Building, Birmingham, Ala., Secretary-Manager.

Southwest Allergy Forum, Shreveport, La., March 31-April 1, 1947. Dr. W. H. Browning, Shreveport, La., President; Dr. Sim Hulsey, Medical Arts Bldg., Fort Worth, Secretary.

Texas Association of Medical Anesthetists, Dallas, May 5, 1947. Dr. Claudia Potter, Temple, President; Dr. Russell Bonham, Box 6237, Houston, Secretary.

Texas Association of Obstetricians and Gynecologists, Fort Worth, November, 1947. Dr. J. E. Kanatser, Wichita Falls, President; Dr. Julius McIver, 714 Medical Arts Building, Dallas, Secretary.

Texas Chapter, American College of Chest Physicians, May 5, 1947. Dr. R. G. McCorkle, San Antonio, President; Dr. Elliott Mendenhall, 1217 Medical Arts Bldg., Dallas, Secretary.

Texas Club of Internists. Dr. N. D. Buie, Marlin, President; Dr. Victor E. Schulze, San Angelo, Secretary.

Texas Hospital Association. Mr. Thomas H. Head, San Angelo, President; Mrs. Ruth Barnhart, 2210 Main St., Dallas, Secretary.

Texas Neuropsychiatric Association, Dallas, May 5, 1947. Dr. Fred T. Rogers, Dallas, President; Dr. David Wade, 604 Capital National Bank Bldg., Austin, Secretary.

Texas Orthopedic Society. Dr. E. A. Cayo, San Antonio, President; Dr. Edward Smith, 1215 Walker Ave., Houston, Secretary.

Texas Pediatric Society, Houston, October, 1947. Dr. J. R. Lemmon, Amarillo, President; Dr. John E. Ashby, 3610 Fairmount, Dallas, Secretary.

Texas Public Health Association, Houston, February, 1948. Dr. S. W. Bohls, San Antonio, President; Mr. Earle W. Sudderth, Dallas County Health Department, Court House, Dallas, Secretary.

Texas Radiological Society. Dr. C. A. Stevenson, Temple, President; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secretary.

Texas Railway and Traumatic Surgical Association, May 5, 1947, Dr. F. L. Snyder, Fort Worth, President; Dr. Ross Trigg, First National Bank Bldg., Fort Worth, Secretary.

Texas Society for Mental Hygiene, San Antonio, April 10-12, 1947. Dr. Jack R. Ewalt, University of Texas Medical Branch, Galveston, President; Mrs. Elizabeth F. Gardner, 1617 Watchhill Road, Austin 21, Executive Secretary.

Texas Society of Gastro-Enterologists and Proctologists, Dallas, May 5, 1947. Dr. Tom E. Smith, Dallas, President; Dr. D. L. Curb, 704 Dallas Ave., Houston, Secretary.

Texas Society of Ophthalmology and Otolaryngology, Houston, December, 1947. Dr. W. E. Vandevere, El Paso, President; Dr. E. D. Dumas, 425 Medical Arts Bldg., San Antonio, Secretary.

Texas Society of Pathologists, Business Session, Dallas. May 7, 1947; Annual Session, Galveston, January 25, 1948. Dr. D. A. Todd, San Antonio, President; Dr. C. T. Ashworth, Southwestern Medical College, Dallas, Secretary.

Texas State Heart Association, Dallas, May 5, 1947. Dr. Robert M. Barton, Dallas, President; Dr. M. B. Whitten, Medical Arts Bldg., Dallas, Secretary.

Texas State Urological Society, Dallas, November or December, 1947. Dr. Jo C. Alexander, Dallas, President; Dr. Hub Isaacks, Medical Arts Bldg., Fort Worth, Secretary.

Texas Surgical Society, Dallas, April 7-8, 1947. Dr. Walter Stuck, San Antonio, President; Dr. Truman G. Blocker, University of Texas Medical Branch, Galveston, Secretary.

Texas Tuberculosis Association, Dallas, September 15-16, 1947. F. K. Dougharty, Liberty, President; Miss Pansy Nichols, 700 Brazos, Austin, Executive Secretary.

Third, Panhandle, District Medical Society, Amarillo, April 8-9, 1947. Dr. W. A. Carroll, Claude, President; Dr. George Powers, Fisk Bldg., Amarillo, Secretary.

Fourth District Medical Society, Coleman, 1947. Dr. Glenn H. Ricks, Brady, President; Dr. J. C. Young, Coleman, Secretary.

Seventh, Austin, District Society, June, 1947. Dr. Robert B. Morrison, Austin, President; Dr. M. I. Brown, Capital National Bank Bldg., Austin, Secretary.

Eighth, Ninth and Tenth Districts Medical Society, Orange, April, 11-12, 1947. Dr. Walter F. Hasskarl, Brenham, President; Dr. George W. Waldron, Medical Arts Bldg., Houston, Secretary.

Eleventh District Society, October, 1947. Dr. L. L. Travis, Jacksonville, President; Dr. C. B. Young, 929 S. Confederate, Tyler, Secretary.

Twelfth, Central Texas, District Society, Marlin, July 8, 1947. Dr. W. Howard Wells, Waco, President; Dr. H. F. Connally, Jr., Amicable Bldg., Waco., Secretary.

Thirteenth, Northwest District Society, Abilene, April 22, 1947. Dr. Frank Hodges, Abilene, President; Dr. Robert C. Stokes, 501 First National Bank Bldg., Fort Worth, Secretary.

Fourteenth District Society, Sherman, June, 1947. Dr. H. Frank Carman, Dallas, President; Dr. James Jeter, Ennis, Secretary.

Fifteenth, Northeast Texas, District Society, Gilmer, Fall, 1947. Dr. Joe Roberts, Longview, President; Dr. S. W. Tenney, Marshall, Secretary.

HOSPITALS NEEDING INTERNS AND RESIDENTS

Methodist Hospital, Dallas. Capacity 206 beds. C. B. Fielder, Superintendent (interns desired, July, 1947).

El Paso City County Hospital, El Paso. Capacity 192 beds. George W. Cook, Col., U. S. A., Ret., Superintendent (3 interns for one year term, graduates of class A medical school only).

All Saints Episcopal Hospital, Fort Worth. Capacity, 110 beds. Approved for graduate residency. Eva M. Wallace, R. N., Superintendent (1 resident immediately; 2 by July 1).

MEDICAL BOARD EXAMINATION

The Texas State Board of Medical Examiners will hold an examination session June 5-7 in Austin, Dr. T. J. Crowe, Dallas, secretary of the board announces.

TEXAS CLUB OF INTERNISTS

The Texas Club of Internists met February 21-22 in San Antonio for the following program by physicians of San Antonio and Brooke General Hospital:

Scope of Neurosurgery in Relief of Intractable Pain—Dr. Ralph Munslow.
Indications for Exploratory Thoracotomy—Dr. Lawrence M. Shefts.
Transthoracic Vagotomy for Peptic Ulcer—Dr. J. W. Nixon.
Clinicopathologic Conference—Dr. S. W. Bohls.
Evaluation of Cardiac Patients As Pregnancy Risks—Dr. Joe Kopecky and Dr. S. Foster Moore.
Carbohydrate Metabolism—Col. Walter Moursund, M. C., A. U. S.
Aralen in the Treatment of 200 Cases of Recurrent Malaria—Lieut. Ellard Yow, M. C., A. U. S.
Thymol Turbidity Test—Lt. Col. Howard A. Van Auken, M. C., A. U. S.
Subacute Disseminated Lupus Erythematosis—Lt. Col. Myles Moursund, M. C., A. U. S.
Certain Fibrocystic Bone Diseases As a Medical Problem—Major Alfred J. Ackerman, M. C., A. U. S.

New officers elected at the meeting include Dr. N. D. Buie, Marlin, President; Dr. Julian Barton, San Antonio, vice-president; and Dr. Victor E. Schulze, San Angelo, secretary.

CANCER SOCIETY HAS FIRST MEETING

The Texas Division of the American Cancer Society held its first annual meeting February 21-22 in Houston, with more than three hundred in attendance. During an opening session and a public meeting, J. Louis Neff, executive director of the Texas Division; Miss Mary Lou King, executive secretary of the Harris County Unit; Mrs. H. B. Ritchie, Athens, Ga., regional commander of the Field Army; Dr. Alton Ochsner, New Orleans; and Frank C. Smith, president of the Texas Division, spoke. The board of directors and a group interested in the campaign against cancer also met.

Scientific meetings for the medical profession were held under auspices of the M. D. Anderson Hospital for Cancer Research, Dr. R. Lee Clark, director. The program was as follows:

February 21

Carcinoma of the Breast:
Clinical Features—Dr. Alton Ochsner, New Orleans.
Pathologic Characteristics—Dr. D. A. Todd, San Antonio.
Carcinoma of the Cervix:
Classification and Its Significance in Prognosis—Dr. John A. Wall, Houston.
Factors in Early Diagnosis—Dr. E. W. Bertner, Houston.
Carcinoma of the Face:
Clinical Features—Dr. Everett S. Lain, Oklahoma City.
The Problem in Texas—Dr. Charles Phillips, Temple.
Cancer of the Rectum:
Relation of the Pathology to Prognosis—Dr. John C. Henthorne, New Orleans.

February 22

Tumor Clinic and Panel Discussion—Drs. Alton Ochsner, New Orleans; Charles Phillips, Temple; Everett Lain, Oklahoma City; H. L. D. Kirkham, Houston; William F. Mengert, Dallas; Violet Keiller, Houston; John C. Henthorne, New Orleans.

The board of directors unanimously elected Tom E. Braniff, Dallas, as chairman of the board; Frank C. Smith, Houston, president; Fred Florence, Dallas, treasurer; and J. Louis Neff, Houston, executive director. The board also accepted the report of the executive committee retaining Dr. E. W. Bertner, Houston, as chairman of the committee, and making Mrs. Oveta Culp Hobby, Houston, honorary commander of the Field Army.

Reports made at the meeting indicate that $89,675 has been appropriated by the Texas Division for basic, fundamental programs of cancer control thus far.

GUERRIERO LECTURE ON APRIL 23

Dr. Arthur H. Curtis, chairman of the Department of Obstetrics and Gynecology, Northwestern University, Chicago, will give the first annual Charles P. Guerriero, Sr., Memorial Lecture at 8:00 p. m., April 23, at Scott Hall, Dallas, on "Consideration of Some Uterine and Ovarian Tumors." The lectureship was given recently to the Department of Obstetrics and Gynecology of the Southwestern Medical College by George W. Guerriero, Monroe, La., and Dr. William F. Guerriero, Dallas, in memory of their father. The lectures will be open to members of the medical profession and allied groups.

NAVAL RESERVE OFFICERS WANTED

The Naval Air Reserve Training Command has seventeen Naval Air Stations throughout the nation at which Naval Reserve medical officers may serve on active duty with full pay and allowances and with the privilege of returning to civilian life at any time on request. There is now a vacancy at the Naval Air Station, Dallas. In addition, medical officers are needed for part-time duty with the Organized Air Reserve. Complete details may be obtained from the Chief of Naval Air Reserve Training, Naval Air Station, Glenview, Ill.

ALLERGY COURSE IN KANSAS

The Mississippi Valley Sectional Instructional Course in Allergy, sponsored by the American College of Allergists under auspices of the University of Kansas School of Medicine, will be given May 5-8 at the University of Kansas Hospitals, Kansas City, Kan. A well balanced program has been planned to cover the basic principles of diagnosis and management of allergic diseases, using round-table discussions, laboratory and clinical sessions, as well as formal lectures.

Physicians practicing general medicine, pediatrics, otolaryngology, or dermatology will find material of interest in the course, details of which may be obtained from Dr. Orval R. Withers, 1418 Bryant Building, Kansas City 6, Mo. Applications for the course and for hotel reservations should be placed with Dr. Withers. The $50 fee for the course is payable upon registration with the University of Kansas School of Medicine.

NEGRO ASSEMBLY CONVENES

The eleventh annual Postgraduate Assembly for Negro physicians was held at Prairie View, March 3-6, according to the Port Arthur *News*. Sponsored by the Texas and National Tuberculosis Associations, State Health Department, Lone Star State Medical, Dental, and Pharmaceutical Association, Prairie View University, and State Medical Association, the assembly presented four special guests. Dr. Thelma Patten-Law, Houston, spoke on obstetrics; Dr. W. Roderick Brown, Pittsburgh, Pa., on tuberculosis; Dr. T. K. Lawless, Chicago, on syphilis; and Dr. W. A. Younge, St. Louis, on internal medicine.

SAFETY CONFERENCE CALLED

The eighth annual Texas Safety Conference, scheduled for May 1-2 at Hotel Texas, Fort Worth, will include a discussion of industrial hygiene and occupational disease laws. These subjects, of most interest to physicians, will be considered in the industrial section. Other sections will concern traffic safety and community safety. Sixty national and state experts will cover all phases of safety at the conference in a program which officials say is the most ambitious yet arranged.

TEXAS PUBLIC HEALTH ASSOCIATION

The Texas Public Health Association met in Dallas, February 23-26, with section programs for health officers, nurses, engineers, clerks, laboratory workers, and sanitarians, in addition to general assemblies. Among out-of-state guests who participated in the program were Dr. Reginald M. Atwater, New York; Dr. Henry F. Vaughn, Ann Arbor; William T. Ingram, New York; Lewis Dodson, Ann Arbor; W. A. Hardenbergh, New York; Dr. Harold A. Wood, St. Louis; and Herb H. Hanson, Battle Creek, Mich. The program, on many phases of public health, was rounded out with addresses from Texas health personnel.

Decision was made to hold the 1948 meeting during February in Houston. New officers, who will serve until that time, include Dr. S. W. Bohls, San Antonio, president; Dr. Austin E. Hill, Houston, president-elect; Miss Faye Pannell, Dallas, first vice-president; Dan T. Bartlett, Dallas, second vice-president; and Earle W. Sudderth, Dallas, secretary.

LIBRARY NOTES

PACKAGE SERVICE

The package library consists of collections of reprints and other periodical material on various subjects, prepared for lending to members of the Association. Requests for packages should be addressed "Library, State Medical Association of Texas, 1404 W. El Paso Street, Fort Worth 3, Texas." Twenty-five cents in stamps should be enclosed with the request to cover postage and part of the expense of collecting the material. Only one package may be borrowed at a time, and packages are allowed to remain in the hands of the borrower for 14 days.

Packages were mailed from the Library of the State Medical Association to the following during March:

Dr. Frank H. Kidd, Dallas—*Wounds, healing* (23 articles).

Dr. G. E. Pryor, Stamford—*Anesthesia, intratracheal* (6 articles).

Dr. Ernestine Smith, Amarillo—*Sclerosis, disseminated* (17 articles).

Dr. Roland F. Knox, Wichita Falls—(2 journals).

Dr. L. C. Heare, Port Arthur—*Glaucoma* ((11 articles).

Dr. Ross Owens, San Antonio—*Anesthesia, in obstetrics and gynecology* (3 articles); *Peptic Ulcer, therapy* (31 articles).

Dr. William F. Rumpf, Dallas—*Enzymes* (7 articles).

Dr. John M. Moore, San Antonio—*Diarrhea, in infants and children* (21 articles); *Fungi* (52 articles).

Dr. Orion Thompson, Tyler—*Nephritis* (22 articles).

Dr. A. S. Epperson, Houston—*Sweat Glands, diseases* (8 articles); *Diabetes Mellitus, therapy* (21 articles).

Dr. Carter Anderson, Jr., Tyler—*Delinquency* (15 articles).

Dr. Joe C. Much, Sugar Land—*Tendons, surgery* (12 articles).

Dr. George T. O'Byrne, Corpus Christi—(7 journals).

Dr. O. M. Marchman, Dallas—*Migraine* (24 articles).

Dr. David M. Marcley, Amarillo—*Neuroses and Psychoneuroses, cardiac* (13 articles).

Dr. H. Klapproth, Sherman—(1 journal).

Dr. Charles Mims, Mission—*Hernia, postoperative* (12 articles); *Wrist, wounds and injuries* (16 articles).

Dr. McKee Caton, McAllen—*Mycetoma* (11 articles).

Dr. Maurice C. Barnes, Waco—*Dermatitis* (38 articles); *Scalp, tumors* (5 articles).

Dr. Titus H. Harris, Galveston—*Medicine, socialized* (6 articles).

Dr. H. L. Wilder, Pampa—*Endometriosis* (20 articles).

Dr. R. C. Stokes, Friona—*Anesthesia, pentothal sodium* (21 articles).

Dr. W. C. Basom, El Paso—(3 journals).

Dr. R. A. Duncan, Amarillo—*Vertigo* (15 articles).

Dr. F. R. Rugeley, Wharton—(4 journals).

Providence Hospital Library, Waco—*Endometriosis* (11 articles).

Dr. Jack Pruitt, Sanatorium—(1 journal).

Dr. G. L. Nesrsta, San Angelo—*Periarteritis, nodosa* (19 articles).

Dr. Lee E. Hale, Lubbock—*Shock, therapy* (17 articles).

Lt. Philip I. Wilson, San Antonio—*Bones, atrophy* (4 articles).

Dr. D. C. Enloe, Sherman—*Blood, groups* (23 articles).

Dr. W. M. Boguskie, Hearne—*Anesthesia, procaine* (7 articles).

Dr. Jesse L. Coleman, Sanatorium—*Venereal Diseases* (19 articles).

Dr. Frank B. Duncan, Amarillo—*Otomycosis* (11 articles).

Dr. Tate Miller, Dallas—*Peptic Ulcer* (22 articles).

Dr. C. E. Adams, Abilene—(2 journals).

Dr. Harry A. Tubbs, Fredericksburg—(1 book).

Dr. Ralph B. Payne, Amarillo—*Vertigo, aural* (16 articles).

Dr. Holloway Bush, Macon, Ga.—*Breast, Paget's Disease* (7 articles).

Dr. C. H. Frank, Texarkana—*Cancer, in infants and children* (11 articles).

Dr. Evelyn G. Powers, Amarillo—*Endometriosis* (11 articles).

Dr. R. C. Miller, Lake Jackson—*Arteriosclerosis* (10 articles).

Dr. C. R. Finnegan, Dallas—*Flatulence* (7 articles).

Dr. Vincent S. Pawelek, Jr., Houston—*Medicine, socialized* (36 articles).

Dr. W. E. McRee, Port Arthur—*Dysmenorrhea* (2 articles); (1 journal).

Dr. W. P. Watkins, Eastland—*Meningitis, influenzal* (23 articles).

Dr. L. R. Byrd, Jr., Port Arthur—*Metatarsus, fractures* (17 articles).

Dr. J. M. Bauknight, Ganado—*Chloroquine* (2 articles).

Nueces County Medical Library, Corpus Christi —*Demerol* (8 articles).

Dr. A. O. McCary, Freeport—*Abortion* (14 articles).

Dr. James B. N. Walker, Brownwood—*Headache* (10 articles).

Dr. E. Filmore Meredith, Olney—*Leukemia, therapy* (18 articles).

Scott & White Clinic Library, Temple—(2 journals).

Dr. W. D. Blassingame, Denison—(10 journals).

Dr. Denton Kerr, Houston—*Medicine, socialized* (6 articles).

Dr. F. Ray Black, Huntsville—*Health* (5 articles).

Dr. F. J. L. Blasingame, Wharton—*Blood, thiouracil* (4 articles).

Dr. A. M. Patterson, Mineral Wells—*Blood, groups* (14 articles).

Dr. M. L. Fuller, Brownwood—*Soil* (5 articles).

Dr. Elliott Mendenhall, Dallas—*Legislation, Medical* (7 articles).

Dr. Charles H. Brown, Wichita Falls—*Phantom Limb* (7 articles).

Dr. William M. Blair, Wharton—*Bursa, inflammation* (15 articles).

Mrs. Thomas M. Jarmon, Tyler—*Ethics, Medical* (9 articles).

Packages on compulsory sickness insurance to superintendents, debate coaches, and students in Texas High Schools, 8.

Accessions

Chicago, University of Chicago Press—Brunschwig: Advanced Abdominal Cancer.

Philadelphia, The Blakiston Company—Hawk, Oser and Summerson: Practical Physiological Chemistry; Merritt, Mettler and Putnam: Fundamentals of Clinical Neurology.

Springfield, Ill., Charles C. Thomas, Publisher—Miller: The Lung; Adriani: Techniques and Procedures of Anesthesia; Pijoan and Yeager: A Handbook of Commonly Used Drugs.

New York, Charles Scribner's Sons—Wheeler and Githens: The American Public Library Building.

Philadelphia, J. B. Lippincott Company—TeLinde: Operative Gynecology; Becker and Obermayer: Modern Dermatology and Syphilology.

Philadelphia, W. B. Saunders Company—DeLee and Greenhill: Principles and Practice of Obstetrics.

Transactions of the American Proctologic Society, privately printed.

Lancaster, Pa., Lancaster Press, Inc.—Nixon: The Medical Story of Early Texas.

Summary

Reprints received, 1,530.	Local users, 49.
Journals received, 209.	Borrowers by mail, 71.
Items consulted, 246.	Packages mailed, 77.
Items taken out, 300.	Items mailed, 858.

Total items consulted and mailed, 1,404.

MOTION PICTURE FILM LIBRARY

Motion picture films on medical subjects, 16 mm., both silent and sound, some in color, and suitable for either medical or lay audiences, are available for loan to county medical societies, hospital staffs, or individual physicians, on request. Borrowers will be required to pay only the cost of shipment of the films, by express, with insurance, and for any damage to films while in the hands of the borrower.

Requests for films should be addressed to "Motion Picture Film Library, State Medical Association of Texas, 1404 West El Paso Street, Fort Worth 3, Texas." A list of available films, with descriptions, will be furnished on request.

The following motion picture films were loaned by the Film Library of the State Medical Association of Texas during March:

Accident Services (Available through the courtesy of British Information Services)—Dr. W. B. Swift, Fort Worth.

Anemia, Erythroblastic (Available through the courtesy of Mead Johnson and Company)—Terrell State Hospital, Terrell, and Gaines Clinic-Hospital, Seminole.

Anesthesia, Intravenous (Available through the courtesy of Abbott Laboratories)—Department of Anesthesia, Baylor Hospital, Dallas.

Anesthesia, Regional (Available through the courtesy of Winthrop Chemical Company)—Medical and Surgical Clinic, Fort Worth.

Another to Conquer (Available through the courtesy of the Texas Tuberculosis Association)—Gaines Clinic-Hospital, Seminole.

Appendicitis In Childhood (Available through the courtesy of Mead Johnson and Company)—Nacogdoches County Medical Society, Nacogdoches, and Crystal City Clinic, Crystal City.

Bleeding Tendency (Available through the courtesy of Mead Johnson and Company)—Dr. Morton N. Goldberg, Fort Worth.

Blood Transfusion (Available through the courtesy of British Information Services)—Crystal City Clinic, Crystal City.

Blood Transfusion, the Technique of (Available through the courtesy of Mead Johnson and Company)—Crystal City Clinic, Crystal City.

Breech Presentation (Available through the courtesy of Mead Johnson and Company)—Postgraduate Assembly, Prairie View University, Prairie View.

Chest Disease, Surgery in (Available through the courtesy of British Information Services)—Medical and Surgical Clinic, Fort Worth.

Cholecystectomy (Available through the courtesy of Mead Johnson and Company)—Dr. W. B. Swift, Fort Worth.

D. D. T., The Story of (Available through the courtesy of British Information Services)—Dr. W. B. Swift, Fort Worth; Rotary International, Seminole; and Terrell State Hospital, Terrell.

Eyes for Tomorrow (Available through the courtesy of Hurst Eye, Ear, Nose, and Throat Hospital-Clinic)—Southwestern University Pre-Medical Society, Georgetown.

Gastrectomy, Safer (Available through the courtesy of Billy Burke Productions)—Dr. W. B. Swift, Fort Worth.

Golden Glory (Available through the courtesy of Standard Brands, Inc.)—Medical and Surgical Clinic, Fort Worth.

Hysterectomy (Available through the courtesy of Mead Johnson and Company)—Dr. W. B. Swift, Fort Worth.

Immunization Against Infectious Diseases (Available through the courtesy of Lederle Laboratories, Inc.)—Southwestern University Pre-Medical Society, Georgetown.

Know for Sure (Available through the courtesy of the Texas State Board of Health)—McCoy Vocational School, I. M. Terrell High School, and the Army Air Field, Fort Worth.

Health Is a Victory (Available through the courtesy of the American Social Hygiene Association)—Army Air Field, Fort Worth.

Let There Be Light (Available through the courtesy of the Medical Department of the U. S. Army)—Lamar College, Beaumont.

Normal Delivery (Available through the courtesy of Mead Johnson and Company)—Postgraduate Assembly, Prairie View University, Prairie View.

Oxygen, The Administration by Oro-Pharyngeal Catheter (Available through the courtesy of Mead Johnson and Company)—State Hospital, Terrell.

Plain Facts (Available through the courtesy of the American Social Hygiene Association)—Bethlehem Center, Guinn School, and Dorcas Charity Club, Fort Worth.

Plaster Casts (Available through the courtesy of

the Medical Department of the U. S. Army)—Dr. W. B. Swift, Fort Worth.

Psychiatry in Action (Available through the courtesy of British Information Services)—Dr. Morton N. Goldberg, Fort Worth.

Repair of Ruptured Membranous Urethra (Available through the courtesy of the Medical Department of the U. S. Army)—Victoria Hospital Staff, Victoria.

Roentgen Pelvimetry (Available through the courtesy of Mead Johnson and Company)—Postgraduate Assembly, Prairie View University, Prairie View.

Salpingography (Available through the courtesy of E. Fougera and Company)—Dr. W. B. Swift, Fort Worth.

Sutures Since Lister (Available through the courtesy of Johnson and Johnson)—Lamar College, Beaumont.

Thoracic Surgery (Available through the courtesy of the Medical Department of the U. S. Army)—Dr. W. B. Swift, Fort Worth.

Urinary Antisepsis (Available through the courtesy of Mead Johnson and Company)—Dr. Morton N. Goldberg, Fort Worth.

Uterosalpingography (Available through the courtesy of E. Fougera and Company)—Dr. W. B. Swift, Fort Worth.

NEW MOTION PICTURES FOR THE FILM LIBRARY

The Motion Picture Film Library of the State Medical Association has received the following films, which are available for loan upon request:

Eyelid Surgery. 16 mm., silent, color, running time, 8 minutes. (Available through the courtesy of Dr. Ray K. Daily, Houston.) This film depicts the Kuhnt-Szymanowski operation for senile ectropion intermarginal blepharoplasty for trichiasis of the upper lid.

As Others See Us. 16 mm., sound, running time, 15 minutes. (Available through the courtesy of the American Hospital Association, Chicago.) This film is intended to impress upon hospital personnel the need for understanding of human factors involved in their relations with patients and visitors.

BOOK REVIEWS

[1]**Cornell Conferences on Therapy.** Volume 1. Edited by Harry Gold, M. D., Managing Editor. Cloth, 322 pages. Price, $3.25. New York, The Macmillan Company, 1946.

Every general practitioner should have this volume for ready reference. It is filled with concise and up-to-date information from a very select group of contributors, each outstanding in his field of practice or research. The subject matter is presented in round-table fashion, but is unusually clear and free of superfluous discussion. Every paragraph carries a usable suggestion or a valuable opinion from the speaker. Dr. Gold has done a masterful job in selecting subjects and contributors and in directing their discussions to the point. Two readings of this book is equal to a month of postgraduate study in any medical center. It is to be hoped that additional volumes will be published each year as a means of keeping up with the rapid changes in therapy. Every physician should own this and future volumes of Cornell Conferences on Therapy.

[2]**The Traumatic Deformities and Disabilities of the Upper Extremity.** By Arthur Steindler, M. D., F. A. C. S., in collaboration with John Louis Marxer, M. D. Cloth. 494 pages. Price, $7.00. Springfield, Ill., Charles C. Thomas, Publisher, 1946.

This is an excellent book and a real tool for the best present day treatment. It is a volume of approximately 500 pages, well documented with illustrations and a large number of case reports to clarify each type of deformity.

A short section is voted to general considerations of traumatic disabilities of the upper extremity, and to discussions of splints, mechanical principles, and techniques.

The major portion of the book takes up the disabilities of special parts, that is, the shoulder, arm, elbow, forearm and wrist, hand and fingers. Each section contains an extensive list of references for additional study, including the best and most recent articles.

The book is attractively presented and the illustrations are clear and well placed.

[3]**Postgraduate Obstetrics.** By William F. Mengert, M. D., Professor and Chairman, Department of Obstetrics and Gynecology, Southwestern Medical College; Chairman, Obstetrics and Gynecology, Parkland Hospital, Dallas, Texas. Cloth, 392 pages, with 123 illustrations. Drawings by Ruth Maxwell Sanders, Department of Medical Art, Southwestern Medical College. Price, $5.00. New York and London, Paul B. Hoeber, Inc., 1947.

This book is the most important and most practical contribution to postgraduate obstetric education for the general practitioner to appear. It points the way to surgical intervention only where indicated. To say, after careful perusal, that this is merely a good book would do it less than justice.

[3]**Gynecological and Obstetrical Pathology,** with Clinical and Endocrine Relations. By Emil Novak, A. B., M. D., D. Sc. (Hon. Dublin) F. A. C. S., Associate in Gynecology, The Johns Hopkins Medical School; Gynecologist, Bon Secours and St. Agnes Hospitals, Baltimore. Second edition with 542 illustrations, 45 in color. Cloth, 570 pages. Price, $7.50. Philadelphia and London, W. B. Saunders Company, 1947.

Dr. Novak's first revision has incorporated all the worth-while additions of knowledge to the medical world made in this subject during the past few years. With several new chapters and new illustrations, this edition now offers a complete guide to the student and teacher in gynecologic pathology.

NEWS

Contributions to this department will be appreciated. News should be of general medical interest, such as public health activities, new hospitals, personal items of more than local value, etc. News for a particular number of the JOURNAL should be in the hands of the Editor not later than the fifteenth of the preceding month.

The Dallas Health Museum, preparatory to conducting a planned program of health education among local industrial workers, held a luncheon conference March 12, at which officials of the museum and civic, medical, and industrial leaders were present, according to the Dallas *News*. Dr. Carl M. Peterson, secretary of the Council on Industrial Health of the American Medical Association, Chicago, spoke to the group. He recommended organization of a community industrial health committee to survey problems and measure facilities for control of industrial illnesses and deaths, and an extensive educational campaign on industrial health, together with estab-

[1]Reviewed by C. Frank Brown, M. D., Dallas.
[2]Reviewed by Felix L. Butte, M. D., Dallas.
[3]Reviewed by H. Reid Robinson, M. D., Department of Obstetrics and Gynecology, Medical Branch, University of Texas, Galveston.

lishment of adequate health departments in industrial plants where possible. Dr. E. H. Cary, president of Southwestern Medical Foundation; Dr. Stanley J. Seeger, national chairman of the Council on Industrial Health of the American Medical Association; and R. L. Thomas, president of the Dallas Health Museum, all of Dallas, were other luncheon speakers.

Research Grants in medicine and allied fields were considered in Houston on February 17 when ten members of the bacteriology and immunology section of the Research Grants Division, U. S. Public Health Service, met, informs the Houston *Press*. Organized in 1945, the Research Grants Division is composed of twenty-one study sections which review applications in their respective fields and make recommendations to the National Advisory Health Council. National Advisory Cancer Council, and National Advisory Mental Health Council, all of which assist the Surgeon General of the Public Health Service. Money appropriated by Congress is allotted to universities, hospitals, and other public and private institutions to conduct research, and to individual students for special studies. Application blanks may be secured from the Research Grants Division, National Institute of Health, U. S. Public Health Service, Bethesda 14, Md. Dr. W. H. Moursund, dean of Baylor University College of Medicine, is a member of the bacteriology and immunology section and invited his colleagues to meet in Houston.

The San Antonio Medical Foundation has received support for its plan to establish a branch of the University of Texas School of Medicine at the Arsenal property in San Antonio, according to the San Antonio *Express*. Directors of the Chamber of Commerce, the city-county planning board, and the Bexar County Medical Society have voted to support the project. Measures to set up such a school are under consideration by the Legislature.

The Dallas Southern Clinical Society presented the first Marchman award for notable research in medicine to Dr. Joseph M. Hill, Dallas, authority on the Rh factor, at its annual dinner in February, reports the Dallas *News*. The plaque, named for Dr. Oscar M. Marchman, first president of the society, will be awarded annually except when there are no outstanding candidates. Officers elected by the society include Drs. Elliott Mendenhall, president; Hudson Dunlap, vice-president; Glenn D. Carlson, secretary; and Howard K. Crutcher, treasurer.

The society plans to begin in June a program of monthly postgraduate courses, to culminate in its annual conference each March, according to the Dallas *Times-Herald*.

Southwestern Medical College received $20,000 to establish a scholarship for worthy students when friends of Dr. E. H. Cary, president of the Southwestern Medical Foundation, celebrated his seventy-fifth birthday at a dinner in the Baker Hotel on February 28, states the Dallas *News*. Approximately five hundred persons were present at the dinner, arranged by officers and trustees of the foundation. Notables among the medical profession from throughout the United States participated in the celebration.

A series of six public lectures on medical subjects was sponsored during March and April by the Southwestern Medical College and Parkland Hospital, reports the Dallas *Medical Journal*. Drs. Tinsley R. Harrison, William F. Mengert, Andres Goth, Carl Moyer, Don P. Morris, and Arthur Grollman were the speakers. Free copies of the lectures will be available upon request to Fred M. Lange, vice-president and managing director at the college.

Baylor University College of Medicine received an additional $800,000 March 1 when Mr. and Mrs. H. R. Cullen, Houston, announced the contribution to help cover construction and equipment costs of a new college building, informs the Houston Press. Trustees of the college had previously explained to Mr. Cullen the need for additional funds to take care of unanticipated costs caused by rising prices. The immediate decision to give the money was made by Mr. Cullen at the founders day banquet of Phi Chi medical fraternity in Houston, following an address by Dr. Eben J. Carey, dean of the Marquette University School of Medicine and chairman of the board of directors of Phi Chi. Dr. Carey had presented the need of more adequate facilities to train physicians, surgeons, and nurses.

University of Texas.—The Alpha Kappa Chapter of Phi Beta Pi medical fraternity has established a memorial lectureship at the University of Texas Medical Branch, Galveston, in honor of Arnold Charles Surman, a senior medical student killed in an airplane crash in 1946. His father, Dr. Arnold C. Surman, Post, is a graduate of the Medical Branch. The first lecture was delivered March 4 by Dr. George E. Burch, associate professor of medicine at Tulane Medical School, New Orleans, who spoke on "Salt and Water Balance in Cardiac Conditions" and conducted a special clinic on cardiac diagnosis.

Dr. Frederick E. Mohs, University of Wisconsin Medical School, on March 8 held a clinic to demonstrate chemosurgical methods in the management of cancer at the University of Texas Medical Branch.

Dr. Honor B. Fell, director of the Strangeways Laboratory, Cambridge, England, spent a week in February at the University of Texas Medical Branch to inspect the research studies in the Tissue Culture Laboratory. Dr. Fell also delivered two addresses while she was in Galveston.

Dr. James B. Conant, president of Harvard University, Cambridge, Mass., visited the University of Texas Medical Branch on February 21, and spoke to faculty and students on "The Growing Relations of Chemistry and Medicine." He emphasized the importance of fundamental detailed studies on the relationships between chemical constitution and biologic action, and described the mobility of carbon in relation to cellular constituents.

The State Board of Medical Examiners visited the University of Texas Medical Branch in February at the invitation of university officials to conduct examinations for February graduates and others who had made applications for licenses, reports the Galveston *News*.

Personals

Dr. B. E. Pickett, Sr., Carrizo Springs, President-Elect of the State Medical Association, was appointed to the State Board of Health by Governor Coke Stevenson shortly before his term of office expired. The appointment, for a term to expire June 12, 1951, has now been approved by the Senate, informs the Carrizo Springs *Javelin*.

Dr. Harold M. Northington, Wharton, and *Dr. John F. Halamicek*, El Campo, have been appointed county health officer and assistant county health officer, respectively, of Wharton County for two-year terms, reports the El Campo. *Citizen*.

Dr. Ralph Bowen, Houston, has been invited to speak on allergic problems at the Louisiana-Mississippi Ophthalmological and Otolaryngological Society meeting in Biloxi, Miss., May 5, states *Medical Records and Annals*.

Dr. J. A. Leggett, after thirty-two years of general practice in Menard, is limiting his work to consultation and emergencies, according to the Menard *News*.

Dr. and Mrs. J. K. Webster, Athens, observed their golden wedding anniversary in February at a family dinner, the Athens *Review* reports.

Dr. Green L. Davidson, Wharton, celebrated his sixtieth year of active practice and his eightieth birthday March 4, according to the Wharton *Spectator*.

Dr. Herman W. Johnson, Houston, spoke on uterine ring dystocia at the annual meeting of the Missouri State Medical Association in Kansas City, March 30-April 2, according to *Medical Record and Annals*.

MARRIAGE

Dr. Alvis Joe Scull, Jr., and Miss Gloria Robison were married in Temple on January 23.

Dr. Gene Jackson and Miss Norma Lee Wampler were married in Temple on January 23.

BIRTHS

To *Dr. and Mrs. A. E. Meisenbach, Jr.*, Dallas, a son, on December 12.

To *Dr. and Mrs. George Elliott Parker (Dr. J. Louise Vick)*, Houston, a daughter, Martha Louise, on December 4.

To *Dr. and Mrs. W. B. West*, Fort Worth, a son, Britton Reed, on January 20.

To *Dr. and Mrs. John L. Roan*, Fort Worth, a daughter, Carol Jean, on January 20.

To *Dr. and Mrs. Thomas K. Young*, Temple, a son, Richard Maury, on January 20.

To *Dr. and Mrs. Con Dudley Hamilton*, Temple, a son, Con Dudley, III, on January 10.

To *Dr. and Mrs. Beckett Howorth, Jr.*, Temple, a son, David Bishop, on February 6.

To *Dr. and Mrs. John A. Wiggins, Jr.*, Fort Worth, a daughter, Patricia Jane, on February 17.

SOCIETY NEWS

Anderson-Houston-Leon Counties Society

March 11, 1947

Anderson-Houston-Leon Counties Medical Society met in Palestine on March 11 to hear a program by physicians from out of the area. Herbert H. Harris and H. E. Prince, Houston, spoke on various problems relative to allergy, and William N. Dickinson, chief of the out-patient service of the Veterans Administration, Waco, discussed medical problems concerning veterans.

Angelina County Society

March 11, 1947

(Reported by James C. Klein, Secretary)

Diseases of the Pituitary Gland—James Greene, Houston.
Penicillin—Donald Chapman, Houston.

Members of the Angelina County Medical Society heard two members of the Baylor University College of Medicine staff when they met for dinner in Lufkin on March 11. James Greene and Donald Chapman, members of the Department of Medicine, spoke on the subjects named above. Byford Denman, Lufkin, arranged the program, at which Gail Medford, Lufkin, presided. Eighteen were present.

Armstrong-Donley-Childress-Collingsworth-Hall Counties Society

February 21, 1947

(Reported by Perry R. Jeter, Secretary)

Congestive Heart Failure—D. M. Marcey, Amarillo.

D. M. Marcey, Amarillo, spoke on congestive heart failure when the Armstrong-Donley-Childress-Collingsworth-Hall Counties Medical Society met February 21 at Memphis. His paper was discussed generally. Sam Broyles, Amarillo, who had been scheduled to present a paper on methods of treatment of prostatic hypertrophy, was unable to be present.

Letters from representatives in the State Legislature, commenting on the basic science measure now pending in the Legislature, were read. The society voted to write the representatives, expressing its appreciation for the support of the basic science bill by one legislator and requesting reasons why the second cannot give his support.

Brown-Comanche-Mills-San Saba Counties Society

March 10, 1947

(Reported by P. M. Wheelis, Secretary)

Traumatic Injuries of the Hand—Howard Wells, Waco.

Fifteen physicians were present for dinner and a meeting of Brown-Comanche-Mills-San Saba Counties Medical Society at Hotel Brownwood on March 10. Howard Wells, Waco, discussed traumatic injuries of the hand.

M. L. Fuller, director of the Brownwood-Brown County Health Unit, offered a list of objectives of his organization for approval by the society. After discussion by H. B. Allen, C. C. Bullard, H. L. Locker, and H. L. Lobestein, Dr. Locker moved that the objectives be approved. After a second by C. C. Bullard, the motion passed unanimously.

The secretary read copy of a letter from Holman Taylor, Fort Worth, Secretary of the State Medical Association, relative to the ethical status of cooperative hospitals.

Colorado-Fayette Counties Society

February 25, 1947

(Reported by C. I. Shult, Secretary)

Heart Disorders Associated with Deficiency Diseases—F. W. B. Rockett, Flatonia.

F. W. B. Rockett, Flatonia, was in charge of the program when Colorado-Fayette Counties Medical Society met February 25 at Schulenberg. Following a dinner attended by members of the auxiliary, the society discussed medical economics and legislation in detail, and made plans to assist in the campaign to pass certain measures pertaining to medicine in the Fiftieth Legislature. Dr. Rockett then presented the paper named above.

Dallas County Society

February 27, 1947

(Reported by W. W. Fowler, Secretary)

Genital Abnormalities in Childhood (lantern slides)—S. S. Baird, Dallas.
Vascular Headaches and Allergy (lantern slides)—Charles B. Shuey, Dallas.
Use of Radioactive Isotopes in Diagnosis and Therapy—J. R. Maxfield, Jr., Dallas.

Dallas County Medical Society met February 27 in the Southwestern Medical College Auditorium, Dallas, with President John G. Young, Dallas, presiding. There were sixty-eight present.

The scientific program outlined above was presented. The paper by S. S. Baird was discussed by Vincent Vermooten, John M. Pace, C. C. Nash, and Harry M. Spence. The paper by Charles B. Shuey was discussed by Ben R. Buford.

W. W. Peter, Washington, D. C., spoke briefly on health education.

Dr. Young announced that the first of a series of preceptorship lectures would be held March 4 at Baylor University Hospital Library under the direction of Henry Winans, whose subject was "Medical Organization." Additional lectures on public relations and malpractice, to be given the first Tuesdays in March and April, were arranged by a committee under the chairmanship of Curtice Rosser, Dallas, for the benefit of applicants for membership in the society.

Dr. Young also introduced five physicians present for the first time.

Eastland-Callahan Counties Society

February 18, 1947

Virus Pneumonia—Erle D. Sellers, Abilene.
Toxemia of Pregnancy—Guy Patillo, Abilene.

Eastland physicians were hosts at a meeting of the Eastland-Callahan Counties Medical Society in Connellee Hotel, Eastland, on February 18. Following a steak dinner, two guests from Abilene presented the scientific program outlined above.

Ellis County Society

Ellis County Medical Society has recently recommended certain steps to be taken by Waxahachie, Ennis, and other communities in Ellis County which it hopes will promote better health. The recommendations concern passage of laws prohibiting the sale of any milk or milk products except those made from pasteurized, grade A milk; establishment of a public abattoir with competent inspectors at which all locally slaughtered meat must be killed; rigid sanitary inspections of restaurants, grocery stores, and similar businesses; sterilization of barber and beauty shop equipment between customers; installation of water and sewage lines to each house; regular collection and disposal of garbage; a plan for adequate mosquito control; employment of a full-time sanitary engineer and necessary assistants; and a general tightening of health regulations and an increase in the public health staff.

El Paso County Society

February 11, 1947

(Reported by W. Compere Basom, Secretary)

Radiation Treatment of Carcinoma of the Cervix—George Turner, El Paso.

El Paso County Medical Society met in the Turner Home, El Paso, on February 11, with J. E. Morrison presiding.

Delphin Von Briesen was in charge of the scientific program, which consisted of a paper by George Turner, El Paso, discussed by J. R. Fuchlow, Francis A. Snidow, C. Boehler, Robert F. Boverie, J. L. Green, and W. W. Waite.

The society agreed that each member should send letters favoring passage of the basic science bill to each Legislator from the area.

Two visitors spoke in behalf of the Providence Memorial Project.

George Edwards, El Paso, was unanimously elected to honorary membership.

February 25, 1947

(Reported by J. R. Herz, Secretary pro tem)

Symptoms of Coronary Heart Disease—Ross W. Rissler, El Paso.

Ross W. Rissler, El Paso, spoke on coronary disease when El Paso County Medical Society met February 25 at the Turner Home, El Paso. His paper was discussed by James J. Gorman, R. H. Homan, E. Reinheimer, B. F. Stevens, L. C. Feener, Leigh Wilcox, and Leo Villareal.

C. Boehler spoke about the nursing situation, locally and nationally. Upon his motion, the society voted that a committee be appointed to work with the directors of the local hospitals in an attempt to solve the problem of the shortage of nurses.

Dr. Morrison announced that the library of the late Dr. Hugh M. Shannon, El Paso, had been donated to the El Paso County Medical Society Library.

Falls County Society

March 10, 1947

(Reported by Neil Buie, Jr., Secretary)

Cancer of the Cervix—Charles L. Martin, Dallas.

Fourteen members and eleven guests were present for the Falls County Medical Society meeting March 10 in the Falls Hotel, Marlin.

Charles L. Martin, Dallas, in his talk on cancer of the cervix, emphasized early diagnosis, adequate radiation, and proper dosage. He opposed surgical procedures for cancer of the cervix and advocated treatment by the radiologist rather than the gynecologist.

George V. Brindley, Temple, Councilor of the Twelfth District, urged members to take a more active part in the county medical society, to develop programs that are short and to the point, and to cut business details at the meetings to a minimum.

Gordon G. Singleton, president of Mary-Hardin-Baylor College, Belton, discussed activities of the American Cancer Society and urged support of its drive for funds.

Galveston County Society

February 25, 1947

Galveston County Medical Society, members of the faculty of the University of Texas Medical Branch, and other guests, totaling almost one hundred, met for dinner and a program by representatives of the National Physicians Committee on February 25 at the Buccaneer Hotel, Galveston. Edward F. Stegen and Arthur Conrad, both of Chicago and both on the administrative staff of the National Physicians Committee, attacked efforts to legislate compulsory sickness insurance programs. Mr. Stegen pointed out that political medicine is an attempt of collectivists to destroy democracy. Mr. Conrad advocated a nationwide check of how the physician stands in his community, a study of the medical profession in other countries, a study of this nation's medical facilities, and a study of textbooks. John McGivney, Galveston, president of the county medical society, presided.

Grayson County Society

February 11, 1947

Medical Legislation and Prepaid Medical Service Plans—C. C. Nash, Dallas.

Grayson County Medical Society met in Sherman on February 11 to hear C. C. Nash, Dallas, Councilor of the Fourteenth District, discuss proposed medical legislation and prepaid medical service plans. Mr. Voorhees, Sherman, explained a health service plan in operation in Sherman. The society voted to investigate the possibilities of enlarging the plan to include both Sherman and Denison.

Hill County Society

February 28, 1947

Treatment of Conditions of the Hand—Howard Wells, Waco.
Medical Treatment of Hyperthyroidism—D. D. Warren, Waco.

Hill County Medical Society met February 28 in Hillsboro for supper and a program given by two Waco physicians. Seven members of the society heard Howard Wells and D. D. Warren discuss the subjects named above.

Lubbock-Crosby Counties Society

March 4, 1947

(Reported by O. R. Hand, Secretary)

Diagnosis of Syphilis (lantern slides)—William H. Gordon, Lubbock.
Treatment of Syphilis with Penicillin—Lee Alexander, Dallas.

Thirty members and four visitors were present for the March 4 meeting of Lubbock-Crosby Counties Medical Society at the Plains Clinic, Lubbock. Pauline Miller, Lubbock, president, presided.

William H. Gordon, Lubbock, discussed the classification of the stages of syphilis and the manifestations, if any, which appear in each. He stressed the following facts regarding diagnosis of syphilis: (1) A positive blood serologic test does not prove a case to be syphilis, nor does a negative serologic test exclude the presence of syphilis; (2) care should be taken to secure history of primary infection or secondary manifestation; (3) characteristic roentgen changes in the bones and teeth, the appearance of the aorta and auscultatory findings in cardiovascular syphilis, ocular manifestations of the disease, neurological symptoms, and spinal fluid studies in latent and late syphilis should receive careful consideration.

Lee Alexander, Dallas, spoke on the use of penicillin in treating syphilis. He reported good results in such treatment, but warned that patients should be checked for relapses or failure. Syphilis can be prevented in the newborn by the use of penicillin, but penicillin should be used with caution in various other types of syphilis to avoid undesirable reactions.

James W. Rollo, Lubbock, discussed the problem of quarantine of communicable diseases. Upon motion by Fred W. Standefer, seconded by Roy Loveless, the society voted that a committee be appointed to draw up a code on the quarantine period. Dr. Miller appointed Dr. Rollo (chairman), B. A. Jenkins, H. E. Mast, M. M. Ewing, and M. H. Benson to the committee.

The society passed a motion by Sam G. Dunn, Lubbock, seconded by Allen T. Stewart, Lubbock, to express its appreciation to the Lubbock Junior Chamber of Commerce for its services in the fly campaign, blood bank, and other public health projects.

Glen B. Payne, Slaton, was elected to membership.

The secretary read several communications.

Pecos-Jeff Davis-Presidio-Brewster Counties Society

March 2, 1947

(Reported by W. E. Lockhart, Secretary)

Modern Trends in Urology (lantern slides)—William Multhauf, El Paso.

Seventeen members and guests of the Pecos-Jeff Davis-Presidio-Brewster Counties Medical Society met for dinner March 2 at the Holland Hotel, Alpine, as guests of Mr. and Mrs. Malone V. Hill, Alpine.

William Multhauf, El Paso urologist, spoke of various urologic problems which are met by the general practitioner. He considered a minor surgical procedure for the treatment of mumps orchitis by simple opening of the tunica vaginalis, surgical treatment of undescended testicle, cystic degeneration at the bladder neck, chronic prostatitis, streptomycin in urinary infections, vitamin E in acute nephritis, penicillin in acute gonorrhea, and increased prevalence of syphilis of the central nervous system.

Unanimous approval was given a motion by John W. Pate, Sanderson, seconded by J. P. Searles, Marfa, authorizing the secretary to arrange a radio program over station KVLF, Alpine, featuring Joel Wright, Alpine, and presenting facts concerning the proposed basic science law.

A motion made by C. E. Oswalt, Fort Stockton, and seconded by Dr. Searles that members of the society present at a meeting defray the expenses of dinner instead of the members being guests of an individual physician was passed unanimously.

Tarrant County Society

February 4, 1947

(Reported by W. P. Higgins, Jr., Secretary)

Dr. I. L. Van Zandt: Biographical Sketch—Gatlin Mitchell, Fort Worth.
Congestive Heart Failure—J. K. Norman, Fort Worth.
Incidence of Malignancy in Nodular Goiter—T. H. Thomason, Fort Worth.
Oxygen Therapy in Heart Disease (motion picture).

Tarrant County Medical Society met February 4 in the Medical Arts Auditorium, Fort Worth, with eighty-eight members and three visitors present. O. M. Phillips, member of the program committee, presided over the program outlined above. Robert H. Mitchell, Hubert R. Hathaway, and Will S. Horn discussed the paper by Dr. Norman. I. M. Ward, John J. Andujar, H. W. Harper, Jr., W. F. Ossenfort, and M. C. Archer, discussed the paper by Dr. Thomason.

May Owen, president, introduced new members. Doyle J. Doss, M. C. Isbell, Hal W. Maxwell, and L. J. Zbranek were elected to membership.

W. B. West, Fort Worth, chairman of the legislative committee, spoke on the basic science bill. He urged members to write their Senator and Representatives and to encourage their patients and friends to write. C. O. Terrell, Jr., and T. C. Terrell joined in the discussion.

February 18, 1947

(Reported by W. P. Higgins, Jr., Secretary)

Dr. W. B. West: A Biographical Sketch—H. W. Harper, Jr., Fort Worth.
Analgesics Commonly Used in Obstetrics—Robert P. McDonald, Fort Worth.
Analgesia—Hubert R. Hathaway, Fort Worth.
Continuous Caudal Analgesia (Motion Picture).

The program outlined above was presented for Tarrant County Medical Society on February 18 in the Medical Arts Auditorium, Fort Worth, with Burgess Sealy, Fort Worth, member of the program committee, presiding. Theron H. Funk, J. W. Garnett, and Grace Hood discussed the paper by Dr. McDonald, and Harold J. Shelley discussed the paper by Dr. Hathaway.

During the business session, May Owen, Fort Worth, president, presided. Sixty-eight members were present.

The society voted to make Dr. E. C. Axtell, Fort Worth, an honorary member and to submit his name to the State Medical Association for consideration as an honorary member. Morris B. Badt was elected to membership.

DeWitt Claunch, Fort Worth, member of the veterans' care committee, reported for the committee. Dr. Badt, who is with the Veterans Administration, reviewed the procedures to be followed in handling service connected disabilities for veterans.

Tom Green-Eight County Society

February 3, 1947

(Reported by H. M. Anderson, Secretary)

Carcinoma of the Stomach—Harry Williams, San Angelo.
Acute Laryngotracheobronchitis—M. W. Everhart, San Angelo.

Forty-two members and guests of Tom Green-Eight County Medical Society met February 3 in Hotel Cactus, San Angelo, with R. M. Finks, San Angelo, president, presiding.

Harry Williams, San Angelo, outlined the symptoms, signs, and roentgen findings of carcinoma of the stomach. He stressed early diagnosis in order for surgery to be successful. W. W. Coulter, W. Grady Mitchell, Carl Kunath, W. E. Schulkey, K. B. Round, and Dr. Herschberger discussed the paper.

M. W. Everhart, San Angelo, presented two cases of acute laryngotracheobronchitis in children. He emphasized early diagnosis, complete rest, chemotherapy, and early tracheotomy. R. M. Arledge, R. J. Axtell, L. K. Tester, and W. B. Butner discussed Dr. Everhart's paper.

Gordon Pilmer, San Angelo, was elected to membership upon transfer from the Cameron-Willacy Counties Medical Society.

February 24, 1947

(Reported by H. M. Anderson, Secretary)

A call meeting of Tom Green Eight County Medical Society was held in the Shannon Hospital, San Angelo, on February 24 with eighteen members present. R. M. Finks, San Angelo, president, presided over a short discussion concerning the basic science bill.

Wharton-Jackson-Matagorda-Fort Bend Counties Society

February, 1947

Tuberculosis of the Skin—R. H. Harrison, Houston.
Treatment of Tuberculosis—William Blair, Wharton.
Diagnosis and Medical Treatment of Tuberculosis — Charles Schoultz, Bay City.
The Basic Science Bill—F. J. L. Blasingame, Wharton.

El Campo physicians were hosts to approximately twenty members of the Wharton-Jackson-Matagorda-Fort Bend Counties Medical Society for dinner at the El Campo Community Center in February. The program outlined above was presented.

Seventh District Society

March 6, 1947

Diseases of the Colon—Edgar Poth, Martin Schneider, Norman Schofield, and Raymond Gregory, University of Texas Medical Branch, Galveston.

Seventh District Medical Society held a clinic meet-

ing March 6 at the Driskill Hotel, Austin, with members of the University of Texas Medical Branch staff participating in a symposium on diseases of the colon.

Representatives of Alcoholics Anonymous addressed the group after dinner. The society unanimously adopted a resolution offered by H. A. Scott, Austin, endorsing the principles and policies of the National Committee for Education of Alcoholism and affiliated groups, particularly with reference to the recognition of alcoholism as a disease.

AUXILIARY NOTES

Officers of the Woman's Auxiliary to the State Medical Association of Texas: President, Mrs. George Turner, El Paso; President-Elect, Mrs. Edward C. Ferguson, Beaumont; First Vice-President, Mrs. L. B. Windham, Tyler; Second Vice-President, Mrs. V. M. Longmire, Temple; Third Vice-President, Mrs. R. E. Clark, Memphis; Fourth Vice-President, Mrs. J. E. Hogan, Big Spring; Corresponding Secretary, Mrs. Robert F. Thompson, El Paso; Recording Secretary, Mrs. M. A. Ramsdell, San Antonio; Publicity Secretary, Mrs. J. F. Campbell, Fort Worth; Treasurer, Mrs. Guy Jones, Dallas; Parliamentarian, Mrs. Joe Nichols, Atlanta.

The Woman's Auxiliary to the American Medical Association, as previously announced, will meet in Atlantic City, N. J., June 9-13. Those who expect to be present should request reservations immediately through Dr. Robert A. Bradley, Chairman, Subcommittee on Hotels, 16 Central Pier, Atlantic City, N. J.

AUXILIARY NEWS

Bexar County Auxiliary entertained with its annual Valentine luncheon honoring San Antonio physicians on February 14 in the Gunter Hotel, San Antonio. Mrs. Dan Russell, president, presided over the 150 members and guests. She introduced officers of the auxiliary: Dr. John Burleson, advisor to the group; and Dr. Layton Cochran, president of the Bexar County Medical Society. Dr. J. B. Copeland spoke briefly on the basic science bill pending in the Legislature. Col. Allen Snyder, who was introduced by Mrs. Amos Graves, was the principal speaker. He pointed to the important contributions of the medical profession in winning the recent war, described interesting phases of wartime medicine, and recounted his experiences with General Douglas MacArthur in the Far East. Mrs. Frank Paschal offered the invocation.

Following the luncheon, members of the auxiliary elected officers for the year as follows: Mrs. Thomas H. Sharp, president; Mrs. August Herff, first vice-president; Mrs. Charles Tennison, second vice-president; Mrs. Roland Kuper, third vice-president; Mrs. J. B. Miller, Jr., fourth vice-president; Mrs. Wheeler Bell, recording secretary; Mrs. Belvin Pritchett, corresponding secretary; Mrs. W. E. Nesbit, treasurer; Mrs. Phillip Magrish, auditor; Mrs. Ferd Lehmann, historian; and Mrs. John Worsham, publicity. The new officers will assume their duties May 1.—Mrs. R. F. Gossett, Publicity Chairman.

Cherokee County Auxiliary honored physicians of the county and other guests with a banquet February 25 at the Liberty Hotel, Jacksonville. Fifty guests were present for the meal and a musical program. Dr. T. M. Jarmon, Tyler, and Dr. E. V. Swift, Palestine, spoke briefly.—Mrs. J. M. Travis.

Dallas County Auxiliary honored Dr. W. L. Hart, dean of Southwestern Medical College, and Dr. Ralph H. Major, professor of medicine, University of Kansas Medical School, Kansas City, Kan., at a luncheon at the Melrose Hotel, Dallas, on March 30. Dr. Major was presented that evening as the first speaker on an annual lectureship on the art of medicine established by the auxiliary for students at Southwestern Medical College and practicing physicians of Dallas and their families. The lecture was open to the public.

At the luncheon Dr. John G. Young, Dallas, spoke on "The Happy Child" and Dr. Elliott Mendenhall, Dallas, on "Current Health Legislation." Mrs. W. B. Carrell, program chairman, introduced the speakers. New officers were presented as follows: Mesdames John M. Pace, president; G. F. Goff, president-elect; John B. Bourland, Jack G. Kerr, and Gordon B. McFarland. vice-presidents; Ridings E. Lee, recording secretary; P. C. Talkington, corresponding secretary; Warren E. Massey, treasurer; O. M. Marchman, parliamentarian; J. L. Goforth, publicity; U. P. Hackney, historian.—Mrs. Ben F. Harrison, Reporter.

Galveston County Auxiliary held a public games party in February at Murdoch's Pier, Galveston, with proceeds going to the student loan fund. Mrs. Jack Ewalt was general chairman, assisted by Mrs. E. B. Ritchie (chairman) and Mrs. William L. Marr, prize committee, and Mrs. Arthur Ruskin, ticket chairman. —Mrs. John L. Otto, President.

Grayson County Auxiliary had a luncheon and business meeting February 7 at Hotel Grayson, Sherman. Thirty-seven members and three guests attended. Mrs. Max Woodward, Sherman, urged that action be taken by all members in behalf of the basic science bill. The new constitution was read by Mrs. W. A. Lee, Denison, and all revisions were accepted by the auxiliary.

Harris County Auxiliary has lost a member in the death February 21, 1947, of *Mrs. John T. Moore*, Houston. Mrs. Moore had been president of the Harris County Auxiliary and State Auxiliary, and was active in the auxiliary of the M. D. Anderson Hospital for Cancer Research, as well as in other civic groups. She is survived by her husband, Dr. John T. Moore; three daughters, Mrs. Jack Lander, Houston; Mrs. Alton M. Reeder, Amarillo, and Miss Ellen Moore, Houston; a son, Thomas W. Moore, Houston; and six grandchildren.

Kerr-Kendall-Gillespie-Bandera Counties Auxiliary held a valentine tea at the home of Mrs. C. C. Jones, Jr., Kerrville, with Mesdames C. C. Jones, Sr., Comfort, and W. E. Gregg, Kerrville, assisting the hostess. Reports on membership, *Hygeia* subscriptions, physical examinations, and talks before lay groups by physicians were heard before refreshments were served. The table was centered with an old-fashioned valentine bearing a miniature bouquet of red and white flowers. The cake was iced in white and covered with red candied cherries.

The auxiliary elected officers March 7 at a meeting in the Blue Bonnet Hotel, Kerrville, for which Mesdames V. J. Sutch, Kerrville; H. P. Reid, Legion; and Paul C. Bruce, Legion, were hostesses. Officers chosen include Mesdames L. L. Keyser, Fredericksburg, president; J. H. Perry, Fredericksburg, first vice-president; C. S. Livingston, Legion, second vice-president; David McCullough, Kerrville, third vice-president; D. E. Packard, Kerrville, secretary; Roger Stevenson, Kerrville, treasurer; R. K. Simpson, Kerrville, parliamentarian; and E. L. Dyer, Kerrville, historian.

Mrs. Lloyd Luna, president of the Kerrville Literary Club, spoke briefly of the club's work, and gave two readings. Mrs. S. E. Thompson, Kerrville, poured tea and Mrs. Livingston served cake from a table decorated with jonquils, ivy, and green tapers.—Mrs. David McCullough, Secretary.

Liberty-Chambers Counties Auxiliary held a business meeting February 13 in the home of Mrs. A. L. Delaney, Liberty. Mrs. Frank Griffin, Liberty, presi-

dent, presided. Seven members and one visitor were present.—Mrs. E. R. Richter, Secretary.

McLennan County Auxiliary heard Dr. Howard Dudgeon, Jr., speak on "Public Relations" at a brunch at Lake Waco Country Club on February 26. Hostesses were Mesdames D. D. Warren (chairman), E. A. Milam, Paul C. Murphey, Clay Weekley, Tom Oliver, Jr., E. C. Brannon, W. L. Crosthwait, and J. W. Hale.

Orange County Auxiliary observed Doctor's Day at a dinner in DeMary's Border Cafe, Orange, on February 14. Twenty-five members of the auxiliary and Orange County physicians were present. Mesdames Leo Peters, Wynne Pearce, and M. E. Becker were hostesses. Accordion music and songs entertained the guests. Red and white carnations and candles were used for decoration.—Mrs. T. O. Woolley, President.

The monthly business meeting of Orange County Auxiliary was held March 11 at the home of Mrs. T. O. Woolley, Orange, president, who presided. Plans were discussed for the district meeting to be held in Orange in April. Mrs. L. J. Peters read an article on the Blue Cross medical prepayment plan, and, as hostess, served refreshments.—Mrs. O. C. Seastrunk.

Tarrant County Auxiliary heard Dr. Charles Martin, Dallas, discuss cancer at a tea at the Woman's Club, Fort Worth, on February 14. The program was directed by Mrs. W. P. Higgins, Jr.

Washington County Auxiliary elected officers at a luncheon meeting in February at the Hotel St. Anthony, Brenham. Mrs. Roger Knolle was elected president; Mrs. H. L. Steinbach, vice-president; Mrs. C. E. Southern, treasurer; Mrs. Gus Heineke, recording secretary; Mrs. Robert A. Hasskarl, corresponding secretary; Mrs. Sam Toubin, parliamentarian; and Mrs. W. F. Hasskarl, reporter. The nominating committee included Mesdames W. F. Tottenham, W. A. Knolle, and Arthur Becker. Mrs. Roger Knolle read a paper on home nursing, and Mrs. Robert A. Hasskarl read a letter from the State Medical Association concerning legislation. Mrs. W. F. Hasskarl, president, presided, and Mrs. Tottenham offered the invocation.

DEATHS*

Dr. Hugh M. Shannon, El Paso, Texas, died January 27, 1947, of a cerebral hemorrhage and hypertension.

The son of Dr. and Mrs. Samuel F. Shannon, Dr. Shannon was born January 30, 1885, at Sewickley, Pa. He attended the public schools there and at Denver. His premedical education was obtained at Pennsylvania Military College, Chester, Pa., and his medical education at Hahnemann Medical College, Philadelphia, from which he was graduated in 1907. He interned at the Hahnemann Hospital, Philadelphia, and remained in that city to practice, specializing in diseases of the genito-urinary tract. Dr. Shannon had been a member of the Pennsylvania National Guard from 1903 until 1913. He was commissioned as a lieutenant in the Medical Corps of the Army in July, 1917; promoted to captain in August, 1918; and honorably discharged in 1920. When he was discharged, he was stationed in El Paso, and he remained to practice in that city until his death. He was appointed captain in the Texas National Guard in 1922, promoted to major in 1923, and retired at his own request in 1937. During World War II he served three years as an examining physician for Selective Service.

Throughout most of his years of residence in Texas, Dr. Shannon was a member of the State Medical Association through El Paso County Medical Society. He was a member of the American Medical Association, Presbyterian Church, Masonic order, Scottish Rite, Heroes of '76, and Veterans of Foreign Wars. He was on the directors' staff of El Maida Temple of the El Paso Shrine and was a past president and life member of the El Paso Chapter of National Sojourners.

Dr. Shannon's wife, the former Katherine Morrin, whom he married in Philadelphia on March 2, 1912, survives.

Dr. William Walker Brandau died February 4, 1947, at his residence in Dallas, Texas, of intestinal intoxication and partial obstruction.

The son of William and Martha Ann (Miller) Brandau, Dr. Brandau was born November 3, 1871, at Perryville, Tenn. He attended public schools in Clarksville, Tenn., and Southwestern Presbyterian University, Memphis, and was graduated in medicine from the Jefferson Medical College, Philadelphia, Pa., in 1900. He interned at Philadelphia General Hospital and took postgraduate work in New York and Philadelphia. Dr. Brandau was in practice in Dallas from 1900 until 1942, when he retired because of his health.

DR. WILLIAM W. BRANDAU

Since 1914 Dr. Brandau had been a member almost continuously of the State Medical Association and American Medical Association through Dallas County Medical Society. He was elected to honorary membership in the state organization in 1946. He was a member of the Methodist Church and a Mason. He was a medical examiner for United States government pensions.

Surviving Dr. Brandau are his wife, the former Miss Elizabeth M. Heywang, whom he married August 30, 1913, and a brother, C. Y. Brandau, Sr., of Tennessee. Other surviving relatives include three nephews who are practicing physicians in Texas: Drs. George M. Brandau and George H. Brandau, both of Houston, and William H. Brandau, Beaumont.

Dr. Porter Guy Bowen, San Antonio, Texas, died February 12, 1947, of cirrhosis of the liver.

The son of Jess and Willie (Price) Bowen, Dr. Bowen was born in 1892 at Lingleville, Texas. He attended McIlhaney Academy and John Tarleton College at Stephenville, Howard Payne at Brownwood, and the University of Texas at Austin. He was graduated from the University of Texas School of Medicine, Galveston, in 1919. Upon his graduation, Dr. Bowen began general practice in San Antonio, where he was active until his death. However, he took postgraduate work in ear, nose, and throat at

*An obituary ordinarily will not be published more than four months after date of death. Coöperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

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Tulane University, New Orleans, in 1927, and since that time he had specialized in that field of practice. Dr. Bowen was one of the ten founders of Medical and Surgical Hospital in 1926, and was a consultant on the hospital staff at the time of his death.

DR. PORTER GUY BOWEN

Since 1921 Dr. Bowen had been a member of the State Medical Association, American Medical Association, and Bexar County Medical Society. He was a member of the Southwest Texas District Medical Society, and the San Antonio Otolaryngological Society, of which he was president in 1943-1944. He was a member of the Church of Christ and of the San Antonio Chamber of Commerce. Dr. Bowen owned and enjoyed a stock farm near San Antonio. He was a member of the Cattleman's Association of Texas.

Surviving Dr. Bowen are his wife, the former Miss Helen Roulings, whom he married June 18, 1921, in San Antonio; a daughter, Miss Nancy Bowen, a student at the University of Texas, Austin; his father, J. N. Bowen, Los Angeles; and one sister, Mrs. Chess Lane, Stephenville. Also surviving is an uncle, Dr. R. E. Bowen, San Antonio.

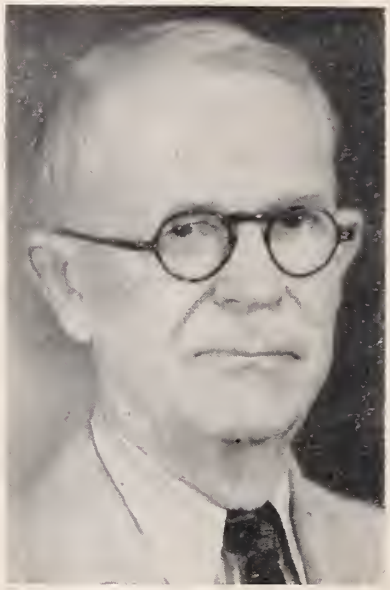
Dr. Henry Pender Ledford, Wichita Falls, Texas, pediatrician, died suddenly February 21, 1947, of heart disease.

Dr. Ledford was born January 29, 1889, in Stockville, N. C., the son of J. S. and Martha Ledford. He attended Mars Hill College, at Mars Hill, N. C., and was graduated in medicine from the University of Tennessee, Nashville, in 1916. He served a one year internship at St. Joseph's Hospital, Memphis, and later took three years of postgraduate training in pediatrics at Harvard University College of Medicine, Boston. Dr. Ledford practiced for one year in Seyppel, Ark., and had been in practice in Wichita Falls since 1921. He was owner and operator of the Ledford Baby and Children Clinic.

Since 1922 Dr. Ledford had been a member of the Wichita County Medical Society, State Medical Association, and American Medical Association. He was president of the county society in 1946. He was also a past president of the Texas Pediatrics Society, and a member of the American Academy of Pediatrics and Southern Medical Association. He was a member of the Shrine, Wichita Falls Chamber of Commerce, and Wichita Falls Country Club. He served as president of the Wichita Falls Optimist Club in 1936-1937, and was voted the club's most valuable member in 1938. At the time of his death he was a member of the Wichita Falls school board and of the board of directors of the Wichita Falls Y. M. C. A. Dr. and Mrs. Ledford in 1946 endowed the Ledford Chair of Music in the senior division of Hardin College, Wichita Falls, in 1946, and also made large donations to the Y. M. C. A. building fund. He was given the Advertising Club's annual award for philanthropy in 1946. He was an active member of the Baptist Church. During World War I Dr. Ledford was cited for bravery and meritorious service with the Army Medical Corps.

Dr. Ledford on March 6, 1928, married Miss Myrtle Hirschi. Surviving are his wife; a daughter, Angela; a son, Joe; two sisters, Mrs. Kate Gardner, Nashville, Tenn., and Mrs. Viola Gardner, Tucson, Ariz.; and two brothers, Tom Ledford, Detroit, and Carvel Ledford, New Orleans.

Dr. Frank H. Carlisle, Italy, Texas, died February 8, 1947, when the car he was driving was struck by a passenger train. The locomotive crashed into the car on a grade crossing in Italy and carried it about three-fourths of a mile before the train could be brought to a halt.



DR. FRANK H. CARLISLE

Dr. Carlisle was born February 22, 1869, in New Albany, Miss., the son of Mr. and Mrs. James F. Carlisle. He attended Memphis Hospital Medical College, Memphis, Tenn., and did postgraduate work at Tulane University Medical College, New Orleans. He practiced a year and a half in Keownville, Miss., and two years in Malone, Texas, before moving to Italy, where he was in active practice until his death, almost fifty years later.

Since 1920 Dr. Carlisle had been a member of Ellis County Medical Society, the State Medical Association, and American Medical Association. He was a member of the Italy Methodist Church, having served forty years on the board of stewards, twenty of which he was president of the board. He was a Mason.

Dr. Carlisle married Miss Blanche King in New Albany, Miss., on July 18, 1889. Survivors include his wife; four daughters, Mrs. S. P. Wilson, Dallas; Mrs. C. G. Hosford, Waxahachie; Mrs. Frank Moore, Italy; and Mrs. Bert Sissom, Blooming Grove; two brothers, Dr. C. P. Carlisle, Dallas, and Fred Carlisle, New Albany, Miss.; and two sisters, Mrs. Sue Garlitz, Fort Worth, and Mrs. Denny Hitt, Ingomar, Miss.

Dr. Irving Taylor Cutter, San Antonio, Texas, died February 18, 1947, of coronary thrombosis.

Born December 9, 1879, at Somerville, Mass., Dr. Cutter was the son of Leonard Francis and Emma Jane (Dow) Cutter. He attended Noble and Greenough's School in Boston, and received both his higher academic and his medical education at Harvard University. He received his bachelor of arts degree in 1903, his doctor of medicine degree in 1907. He served a one year internship and a one year residency at Boston City Hospital. He then practiced in Boston for two years and in Winchester, Mass., for

thirteen years before moving to San Antonio, where he had been in practice for twenty-four years. His specialty was obstetrics.

Throughout his professional career Dr. Cutter was a member of the American Medical Association. He had been a member of Bexar County Medical Society and the State Medical Association of Texas since 1923. He was a member of the Southern Medical Association, a fellow of the American College of Surgeons, and an honorary member of the Texas Association of Obstetricians and Gynecologists. He was a member of the Aesculapian Club of Boston and of Phi Eta fraternity. He had been chief of obstetrics at Nix Hospital and a member of the staffs of Santa Rosa, Medical and Surgical, and Physicians and Surgeons Hospitals. For sixteen years Dr. Cutter was a member of the National Guard of Massachusetts, and during World War I he was in command of a field hospital, with the rank of major.

Dr. Cutter married Miss Zula Frances Robinson in Las Cruces, N. Mex., on October 6, 1918. Survivors include his wife; two sons, Irving Taylor Cutter and Richard R. Cutter, both of San Antonio; one sister, Mrs. Lillian Cutter Porter, Brookline, Mass.; and three grandchildren.

Dr. Rogers Coke, Marshall, Texas, died at his home February 11, 1947, of cerebral hemorrhage.

Dr. Coke was born in Jefferson, Texas, May 19, 1876, the son of John Edward and Frances (Spellings) Coke. He attended both public and private schools in Jefferson and was graduated from the medical department of the University of Texas, Galveston, in 1899. Following his internship, he practiced in Jefferson for two years before moving to Marshall, where he was in practice until his death. He had taken postgraduate work in New York, Chicago, and Rochester, Minn.

Throughout his professional career Dr. Coke was a member of the Harrison County Medical Society, Northeast Texas District Medical Society, State Medical Association, and American Medical Association. He had served as president of the county and district medical societies. He was a fellow and a life member of the American College of Surgeons. He was chairman of the board of Kahn Memorial Hospital for many years and was regional chairman of the Selective Service Medical Advisory Board during World War II. He was a member of the A. M. P. O. medical fraternity, the Presbyterian Church, a thirty-second degree Mason, a Shriner, and a former Rotarian.

DR. ROGERS COKE

Surviving Dr. Coke are his wife, the former Miss Norma Crawford Nickell, of Millboro, Va., whom he married in 1911; one daughter, Mrs. Nelson Waggener, Dallas; two sons, Rogers Coke, Jr., Galveston, and Crawford Coke, Austin; and two grandchildren.

Dr. Charles Leslie Edgar, Cleburne, Texas, died February 15, 1947, in a Temple hospital of complications following a fractured leg.

The son of Mr. and Mrs. Charles W. Edgar, Dr. Edgar was born May 1, 1872, near Corsicana. He was graduated from the medical department of old Fort Worth University in 1898, and took postgraduate work in eye, ear, nose, and throat at the New York Polyclinic. He practiced three years in Richland, fifteen years in Childress, two years in Fort Worth, and thirty-four years in Cleburne, where he specialized in eye, ear, nose, and throat.

DR. CHARLES L. EDGAR

Dr. Edgar was a member of the State Medical Association and American Medical Association from 1908 until his death, first through Tarrant and Childress Counties Medical Societies, and then through Johnson County Medical Society. He was local physician for the Santa Fe Railway from 1914 until 1947. He was a member of the Methodist Church, serving on the board of stewards.

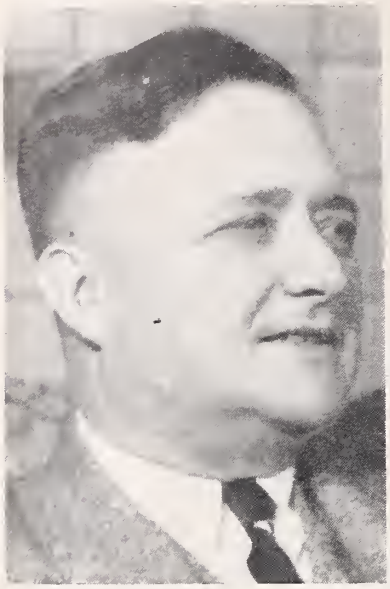
Survivors include Dr. Edgar's wife, the former Mrs. Carrie K. Turner, whom he married October 23, 1901, at Wortham; two sons, R. L. Edgar, Dallas, and C. R. Edgar, Hamilton; one daughter, Mrs. John B. Ezell, Alvarado; one brother, Dr. J. H. Edgar, Richland; and five sisters, Mrs. Lee England, Richland; Mrs. Nell Bush, Mrs. Lillie Jones, and Mrs. Jessie Humphreys, all of Corsicana; and Mrs. Willie Evans, Ruidoso, N. Mex.

Dr. Wreno Edgar Smith, Dallas, Texas, died February 2, 1947, of coronary occlusion.

Dr. Smith was born in Attala, Ala., May 21, 1891, the son of Marion Isaac and Martha Smith. He attended public schools in Alabama and Southern Methodist University, Dallas. He was graduated from the old Southern Methodist University Medical Department in 1914, and later did postgraduate work at Harvard Medical School, Boston. Dr. Smith served an internship and four years as house physician at St. Paul's Hospital, Dallas, was associated at various times with Mercy Hospital, Chicago; St. Joseph's Hospital, Chicago; Massachusetts General Hospital, Boston; Bellevue Hospital, New York; and Mayo Clinic, Rochester, Minn., and had been chairman of the surgical section of St. Paul's Hospital Clinic, Dallas, since its establishment. He was a captain in the Army Medical Reserve for two years during World War I, but had engaged in the practice of surgery in Dallas continuously since 1919.

Almost continuously since 1916 Dr. Smith was a member of the Dallas County Medical Society, State Medical Association, and American Medical Associ-

ation. He was a member and fellow of the American College of Surgeons, and a member of Theta Kappa Phi medical fraternity. He was a member of St. Edward's Church and the Knights of Columbus.



DR. W. EDGAR SMITH

On June 11, 1916, Dr. Smith married Miss Frances Estelle Hickey in Ennis. He is survived by his wife; two sons, Wreno Edgar Smith, Jr., Dallas, and Charles Robert Smith, Baylor University College of Medicine, Houston; two daughters, Mary Anne Smith and Martha Jane Smith, Baylor Dallas; three brothers, Clyde Smith, Dallas; Gaines Smith, Oklahoma City, Okla.; and Julian Smith, Kingston, Okla.; and four sisters, Mrs. L. N. Stickney, Waxahachie; Mrs. A. Harrell, Bynum; Mrs. Herman Youngblood, Corsicana; and Mrs. Della Rich, Blanchard, Okla.

Dr. Robert Sherod Yancey, Dallas, Texas, died February 21, 1947, of heart disease.

Dr. Yancey, son of C. S. and Rozzell Yancey, was born in Armstrong, Mo., July 21, 1872. He was graduated from old Missouri Medical College, St. Louis, in 1897, and went to Sedalia, Mo., as house surgeon at a hospital of the Missouri-Kansas-Texas Employes' Hospital Association. He was soon promoted to division surgeon for the association and moved to Denison, Texas. Dr. Yancey resigned his position in 1906 to take postgraduate work in New York. He returned to Texas in 1911, practicing privately in Dallas in the specialty of eye, ear, nose, and throat. He also served the M-K-T Hospital Association as division oculist, and in 1918 was made chief oculist for the system. In 1937 he was appointed chief surgeon for both the M-K-T Employes' Hospital Association and the Missouri-Kansas-Texas Railroad, and held both positions at the time of his death.

DR. ROBERT S. YANCEY

Throughout his professional career Dr. Yancey was a member of the American Medical Association. He was a member of the State Medical Association through Dallas County Medical Society, and a fellow of the American College of Surgeons. He was a charter member of the Dallas Athletic Club and the Dallas Country Club, and was a member of Sigma Nu fraternity.

Dr. Yancey is survived by his wife, the former Miss Martha Foster, whom he married in 1904 at Denison; two sons, Sherod Foster Yancey and Charles S. Yancey, both of Dallas; one brother, Stephen Yancey, and two sisters, Miss Rozzell Yancey and Miss Ethel Yancey, all of Armstrong, Mo.

Dr. William Blandin Nies, Fort Worth, Texas, died January 7, 1947, following a two year illness with heart disease.

A native of Fort Worth, Dr. Nies was born January 29, 1889, the son of George and Eudora Nies. He attended the local public schools, old Fort Worth University, and Texas Christian University, from which he was graduated with a bachelor of arts degree in 1912 and a doctor of medicine degree in 1916. He interned at St. Joseph's Infirmary, Fort Worth, was assistant city physician for several years, and in 1922 became assistant county physician. He was assistant county health officer from 1934 until 1937, when he became director of Tarrant County Health Unit. In 1936 he did postgraduate work in public health at Vanderbilt University, Nashville, Tenn.

DR. W. B. NIES

Throughout most of his professional career Dr. Nies was a member of the State Medical Association and American Medical Association through the Tarrant County Medical Society. He was a member of the Texas Public Health Association, American Public Health Association, and Association of Military Surgeons. He was a member of the Methodist Church, Masonic order, and Fort Worth Chamber of Commerce.

Dr. Nies was preceded in death on September 14, 1931, by his wife, the former Miss Georgia Belle Taylor, whom he married in Fort Worth on October 16, 1916. A daughter, Miss Sarah Nies, Fort Worth, survives.

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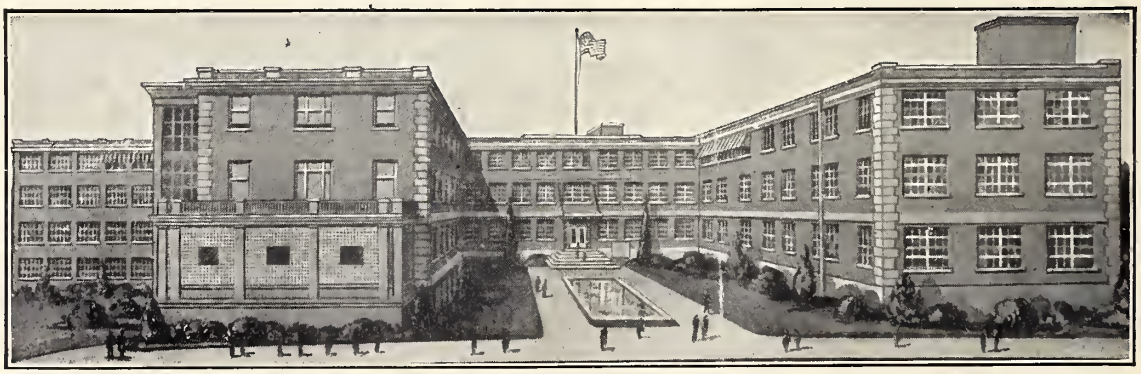

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